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CUTANEOUS (AND GENITO-
URINARY) DISEASES including
Syphilis

EDITED BY
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JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES.

VOL. XV.

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NO. 1.

Announcement.

THE JOURNAL's readers have already received notice through an item in the December number of the contemplated change in its editorship and management. There is a natural hesitancy in taking up this work where Dr. Piffard, Dr. Morrow and Dr. Fordyce have left it. For, as we have reason to know, many men have a pride in the only periodical of its kind in this country, a paper in which so much of the country's good work has appeared. The standard set is correspondingly high. The presumption is fair, however, that if the work goes on as in the past there will be no just cause for complaint. In return, we claim the same measure of support accorded our predecessors—a larger share from the genito-urinary workers who have not of late occupied their allotted part in the space devoted to original communications.

Following the lead of other journals devoted to special fields in medicine, we have added as coöperators in the editorship the men whose names appear on the cover, and constitute a guarantee of the work to be done. They will contribute articles from time to time, the majority of them one or more within the year. In addition, it is our pleasure to announce a series of monographs on malignant new growths of the skin, Dr. Bowen opening with sarcomatosis cutis, Dr. Fordyce following with the superficial forms of epithelioma and the conditions which precede them.

An innovation will be made in the shape of editorials on questions of general interest, serumtherapy in syphilis, syphilitic reinfection, and the present status of parasitism in skin-disease. They will be signed, and are intended to present a *résumé* of recent research in each subject.

A new department, under the name of Clinical Notes, will contain

those communications, which, valuable enough in themselves, are hardly admissible to a place among original articles.

THE JOURNAL will be permanently enlarged eight pages, for the accommodation of the department of selections and therapeutic notes. Dr. Swinburne will have charge of the abstracts in venereal and genito-urinary, Dr. Johnston in cutaneous disease. In the event of the success hoped for in publishing the magazine, a second signature of eight pages will be added.

Other departments will be continued as before, with the exception of the Genito-Urinary Section of the New York Academy of Medicine. Its transactions will appear only when of special interest, for the reason that they are reported in weeklies before this journal goes to press. Following numerous suggestions, we shall publish a bibliography, carefully corrected by the *Index Medicus*, of the literature of skin, venereal and genito-urinary disease, beginning with January, 1897.

It has been the custom to begin the year with a chromolithograph; owing to editorial exigency, its appearance is deferred to next month. Half-tone illustration will be continued as usual; colored plates, on account of their great cost, only when absolutely necessary to depict the clinical features of an unfamiliar disease.

THE EDITORS.

Original Communications.

PRURIGO.¹

By JAMES C. WHITE, M.D.,

Professor of Dermatology in Harvard University.

WHEN I was honored by the request of the Committee of this Congress to take part, with the distinguished gentlemen appointed from France, Austria, and England, in the discussion of this obscure subject, the question naturally arose in my mind: Why select a representative from a country where the least can be known about it, because the disease is there least prevalent? May faith in the adage, *Lucus a non lucendo*, have suggested to them that as our positive knowledge of the affection is so slight, possibly something might be learned by a study of its negative relations?

And first let me, on the part of my American colleagues, make a

¹ Read at the International Dermatological Congress at London, August, 1896.

distinct statement as to our interpretation of the term prurigo. We have almost without exception had the privilege of studying the disease in its true home, Vienna; the oldest of us under the great master, Hebra, who first established its individuality. The American school of dermatology, more than that of any other nation, grew up under his docental care, and regards his memory with reverent honor. His type, therefore, has always been our prurigo. During my student days in Vienna, at a period earlier, perhaps, than that of any of my hearers, in 1856 and 1857, I had ample opportunity of studying the disease under his instruction. In the report of his clinic for the year 1855 the occurrence of seventy-five cases of prurigo in a total of 3375 patients was recorded. I became, therefore, sufficiently familiar with the disease, and came to regard it as one of the ordinary affections of the skin.

On my return to Boston I missed it both in my public clinic and in my private practice. It was wholly absent from both. A doubt even began to arise as to whether there were indeed any such independent affection.

In 1876, I presented to the International Medical Congress, which met in Philadelphia, a paper on "Variations in Type and in Prevalence of Diseases of the Skin in Different Countries of Equal Civilization." In one of the tables, showing the comparative prevalence of some of the more common diseases in American and European practice, ten thousand cases of skin disease under the observation of well-known dermatologists in the United States, all of whom had studied in Vienna, were placed by the side of 24,000 cases under the care of Professor Hebra. Among the latter were 740 of prurigo, while not a single instance was recorded in the American list. I had no hesitation then in assigning its place among "skin diseases of well-established character and recognized occurrence in Europe, which are wholly absent in the United States," and remarked: "How can we account for this striking variation in the prevalence of so well-defined an affection, for its entire absence from this country? There is nothing in its pathology or known etiology to assist us in this direction. Its prevalence is greatest in the country which, of all Europe, presents the greatest diversity in races. We can only blindly congratulate ourselves on the absence of this life-long and well-nigh incurable disease."

At the first meeting of the American Dermatological Association in 1877, an apparently typical case of prurigo in a child of German parentage was reported by Dr. Campbell, and in the discussion which followed it appeared that only six genuine or suspected cases had

been observed in the United States up to that date by the members of the association in attendance.

From this date we have no perfectly reliable reports upon the prevalence of the disease until 1889. At the meeting of the Association of that year, Dr. Zeisler of Chicago presented a paper on the occurrence of prurigo in America, in which he stated that during his five years' residence in that city he had observed twelve cases, of which five were severe, the remainder of mild type. There can be no question as to the correctness of the diagnosis in these cases, as the reporter had had exceptional opportunities of studying the disease in his former home, Vienna. But it is to be especially noted that in one instance only was the patient born of American parents. In the discussion which followed fifteen of the leading dermatologists of the country took part, and not one of them had seen more than one or two typical cases of the disease in dispensary or private practice. Five of them had never seen an entirely unmistakable example, and some of the members expressed a continued doubt as to the existence of such an independent affection, and the belief that cases thus designated were really only papular eczema, secondary to pruritus.

In conclusion, to bring this historical presentation of the prevalence of the disease in the United States down to the present decade, I may be permitted to refer to a paper read by myself before our National Dermatological Association in 1890, on "Immigrant Dermatoses," in which I make the following statement with regard to prurigo: "It would appear, then, that prurigo is becoming more prevalent among us, or that dermatologists recognize it more readily than previously, or are more disposed to give this name to conditions of the skin which they formerly placed among other affections. I believe that true prurigo is still an extremely rare autochthonal disease in America. That it is becoming a more noticeable imported affection is equally true, no doubt, and it is in such towns as New York and Chicago, where there is an enormous resident German population, that we may expect to find such evidence of it as is shown in our recent annual returns, and in the interesting data furnished by Dr. Zeisler above referred to." This opinion has not been modified by observation during the past five years. By contrast, I quote from a recent communication from Professor Neisser to my son, Dr. Charles J. White, which shows the prevalence of the disease in Breslau in recent years. The number of cases of prurigo under treatment in his clinic was, in 1887, 45; in 1888, 62; in 1889, 56; in 1890, 59; in 1891, 53.

Now how shall we account for this striking inequality in prevalence of an affection, in which neither the pathological tissue-changes, nor any hitherto recognized etiological factors offer the suggestion of a solution? There are imported dermatoses, also sparsely observed in the United States, like melanosis lenticularis progressiva (Pick), Kaposi's xeroderma pigmentosum, which present such strange features in these and other relations, that we more willingly accept geographical or ethnical influences as possible agencies in the mystery of their occurrence. Not so with one, the nature of which is so very commonplace as that of prurigo, for, however much dermatologists may differ as to its earliest manifestations, their anatomy, and course, there can be no question that none of these features are exclusively characteristic of the affection, and that its individuality, if this be granted, rests wholly upon certain peculiarities of association of ordinary symptoms. If we adhere to the simple Hebra type, perpetuated in his graphic description, or admit the exceptional deviations from it, pointed out by so many skilled observers in different parts of Europe in recent writings and discussions, there are no individual features of the disease in one or another combination which are not of common occurrence with us in America. Infantile urticaria is a very frequent affection. It often becomes chronic, and the characteristic wheals dwindle into persistent inflammatory papular lesions, and have associated with them early and later excoriations and all sorts of eczematous phenomena. They might readily be called in many instances examples of the early stages of prurigo, but they do not persist long enough, and I cannot recall a single case which under continued observation has eventuated in such serious fashion. Again, if we are to regard prurigo, if not as a modified urticaria, still as some sort of a neurosis, and all its visible manifestations as secondary and provoked by scratching, then America should offer an exceptional field for its development, for pruritus is with us almost a national trait. With the beginning of the cold season, in the Northern and Western States at least, when thicker and rougher underclothing is put on, and the internal temperature of dwellings is unduly raised by artificial heat, and the atmosphere is drier than at other times of the year, then a considerable percentage of the population is affected by a more or less general pruritus, which persists for months continuously, and leads to all sorts of secondary changes in the skin, according to individual temperament of its tissues. Simple mechanical excoriations, urticaria, and many clinical varieties of eczema being its chief sequelæ.

There is another kind of pruritus, which begins in the earliest

years, and is independent of the seasons, and persists continuously and indefinitely. The patient scratches incessantly, mostly on parts of easiest access, hands and head by day, all parts by night. No portions of the general surface are exempt, flexures of the joints, neck and face are as much torn as the special seats of predilection in prurigo; indeed, the face and scalp are often in a continual state of uniform eczema of intense grade. Such patients may be termed perpetual scratchers, and are striking examples of the chronic neurotic skin. Yet they are readily distinguishable from cases of prurigo ferox, which they closely simulate in course and subjective phenomena.

If then prurigo be only a sequel of urticaria, a neurosis, pruritus, or disorder of sensibility, with subsequent objective manifestations due to scratching, surely it should prevail with us in the United States abundantly. Such etiological conditions cannot be more favorable elsewhere, and yet the disease is one of extreme rarity, except by importation more or less direct.

Can ethnical differences possibly account for such infrequent occurrence? Our population is the most varied of any existing nation, although very little mixed by intermarriage on any large scale. Vast areas are peopled largely by immigrants of one or another race, as the so-called Scandinavian States, the French districts in Canada, and some of our large cities contain enormous representations of foreign stock settled in their respective quarters. Thus New York is one of the largest German towns in the world. Our immense mining regions present great colonies of Welsh, Poles, and Hungarians, and Russians, Hebrews, and Italians come in hordes to America. Here is a list of the European-born population of the United States in 1890:

| | |
|-------------------|-----------|
| From Germany..... | 2,784,894 |
| Ireland..... | 1,871,509 |
| England..... | 909,092 |
| Sweden..... | 478,041 |
| Norway..... | 322,665 |
| Scotland..... | 242,231 |
| Russia..... | 182,644 |
| Italy..... | 182,580 |
| Poland..... | 147,440 |
| Denmark..... | 132,543 |
| Austria..... | 123,771 |
| Bohemia..... | 118,106 |
| France..... | 113,174 |
| Switzerland..... | 104,069 |

| | |
|-----------------------|---------|
| Wales | 103,079 |
| Netherlands | 81,828 |
| Hungary | 62,435 |
| Belgium and Luxemburg | 25,521 |
| Portugal | 15,996 |
| Spain | 6,185 |
| Greece | 1,887 |

I give also a table of immigration from the same countries into the United States in the last five years, ending June 30, 1895:

| | |
|-------------|---------|
| Germany | 436,410 |
| Ireland | 242,282 |
| England | 211,398 |
| Sweden | 152,495 |
| Norway | 59,349 |
| Scotland | 49,374 |
| Russia | 226,363 |
| Italy | 292,035 |
| Poland | 77,032 |
| Denmark | 39,856 |
| Austria | 133,090 |
| Bohemia | 29,982 |
| France | 26,013 |
| Switzerland | 25,555 |
| Wales | 5,428 |
| Netherlands | 25,812 |
| Hungary | 118,706 |
| Belgium | 15,049 |
| Portugal | 10,365 |
| Spain | 4,607 |
| Greece | 4,807 |

Grouped by races they give the following figures:

| | |
|--------------------------------|---------|
| Ireland, England, and Scotland | 413,267 |
| Russia and Poland | 303,395 |
| Austria, Hungary, and Bohemia | 281,778 |
| Sweden, Norway, and Denmark | 251,700 |

Total immigration from Europe in the same period, 2,217,761.

Again, all possible climatic and telluric conditions exist with us.

It is evident, therefore, that an extraordinary field for the study of disease due to racial peculiarities is offered to the dermatologist in the United States, and it is true also that with the large number of trained observers in our specialty now scattered over our wide

domain, no form of dermatosis is likely to occur without their cognizance. It may be fairly claimed that the returns of our National Dermatological Association may be accepted as a reliable census of the prevalence of cutaneous affections in North America.

If then prurigo be an almost unknown disease among the American people as a whole, and it be observed only as of rarest occurrence in immigrants from European countries, and their descendants, where it is of common occurrence, it is evident that the explanation of such exemption on removal to the United States must be sought in the altered conditions of living there. With the higher wages received, and the reduced cost of food of all kinds in America, a more abundant, more varied, and richer diet is provided for his family by the laborer than in his former home. His dwelling, too, is greatly improved, less crowded, and better furnished with sanitary appliances, and means of securing personal cleanliness. It is inconceivable by one who has not had opportunity of personal observation, the indescribable filthiness of person and underclothing of whole classes of recent immigrants. They are indeed "the great unwashed." Incrustations of fecal matter, dried catamenial discharges, black encasements of sweat and urine mixed with foreign matters, representing the habitual state of the general surface concealed by foul clothing; while above all this filth the face may present a habitual fairness and cleanliness to view.

In time they learn to correct such bestial habits, and to pay some decent attention to the care of the skin.

If, then, prurigo be a disease chiefly affecting the poor and ill-nourished classes, as European observers declare, it should not be surprising that with the improved general nutrition and better care of the skin consequent upon their change of living, they should largely cease to be subject to its development in their new home; and, if we be warranted in according so much influence to hygiene upon the arrest or suppression of prurigo, it follows, that we must give to a total disregard of its laws equal importance as an etiological factor in part or in chief. How far, in fact, may we accept such a conclusion as sufficient and reconcilable with our little definite knowledge of its causes or the opinions of those who have had the best facilities of studying it? I do not mean *what* it is, that is whether it be a mere neurosis of one kind or another, whether the eruption be primary or secondary, whether the papule or wheal be the earlier and essential lesion, whether, in fact, it be merely a complex condition, or an independent disease, but *why* it is? I have examined the writings of some forty well-known dermatologists of all countries, who have

published articles or chapters upon prurigo, and find that, although many and various opinions have been expressed upon its pathology, hardly any definite opinions as to its causation are contained in them. Hebra's original statement was that it "occurs almost exclusively in poor subjects and those ill-nourished in childhood, and so most often in foundlings and beggar's children, while those who have enjoyed a good physical education in early youth, and have always been properly fed according to their age, suffer very rarely indeed from prurigo" (Sydenh. translation). Here is a conclusion from observation having a possible bearing on the development of the disease, but when we turn to such vague phrases as "dyscrasy," "arthritis," "nervoism," etc., we are in the realm of absolute intangibility, beyond the comprehension of some of us, and admitting no discussion. It may be fairly stated then that defective nutrition, unhygienic surroundings, and negligence toward the skin are the only positive factors which have been recognized as bearing upon the etiology of the disease, and that its greatly diminished occurrence, or well-nigh absence, in countries where these conditions are least likely to prevail, as England and the United States, offers strong corroborative evidence of the truth of such a conclusion.

And now it is in order again to raise the question: If, after all, there be really any one independent condition of the skin, characterized by so definite a course, by such uniform anatomical changes, by a pathology concerning which there is such consonance of expert opinion, by the identity of type in all countries, that its individuality should be accepted by us without question? If a skilled dermatologist, educated, let us say, exclusively in the United States, was for the first time to take up the study of the disease solely from the extensive literature of the subject, would he not be justified in doubting the existence of such a real affection? Is there such discordance of opinion with regard to all the essential features of any well-recognized dermatosis? An appreciation of this status may perhaps have led the officers of this Congress to select this title as the first subject for discussion. Let us consider briefly some of these discrepancies in the views of observers, using Hebra's original description as our standard of comparison.

Course.—According to this every case has its origin in infancy, and "the opinion that the disease first appears in adult life it therefore incorrect."

Besnier and Doyon¹ deny the invariable beginning in the first years of infancy, and say that it occurs also in second infancy and

adolescence. That it is no more exempt from exceptions than other affections.

Ehlers² says it begins most often between the second and seventh years of life, and as late as the twenty-ninth.

Vidal³ states that it does not always begin in early infancy.

Neisser⁴ also that it does not always begin in earliest infancy.

Several observers differ, moreover, with Hebra in the opinion that the disease is always worse in winter, and few dermatologists agree with him as to its incurability.

Character of Eruption.—According to Hebra's description "in every case the earliest appearance is that of subepidermal papules, as big as hemp seeds, and recognized rather by touch than by sight."

Kaposi, in his lectures (edition 1879), says the disease begins from the eighth to the twelfth month, first wheals, and no papules, until the end of the first or beginning of the second year.

Hebra fil⁵: Wheals are the only lesion in the first year or two, combined with pruritus. The characteristic papules come later, and are the result of scratching. They are never the first symptoms.

Tommasoli⁶: At first, pruritus and coincident appearance of the characteristic papules, preceded or accompanied by wheals.

Mibelli⁷: Disease is characterized by peculiar papules, with occasional vesicles and wheals.

Ehlers² considers the papules as secondary to scratching.

Vidal³ maintained in his paper before the Vienna Congress that pruritus precedes the papules, and that they and the accompanying wheals in infantile cases are due to scratching.

Neisser⁴ recognizes a prodromal urticaria-like eruption, leading to the development of a superficial papular efflorescence.

Riehl⁸ believes there is an intimate relationship between the papules and the urticarial efflorescence, and that in infancy the former often develops into the latter.

Neumann⁹: Papules are the primary manifestation.

Behrend¹⁰: The disease begins as an urticaria papulosa.

Schwimmer¹¹: Wheel-like efflorescences not only precede the beginning of the disease, but the subsequent attacks as well.

Lesser¹²: The diagnosis in the first year or two is very difficult, but every persistent urticaria at that age is suspicious.

Auspitz¹³: The papule plays no more important part than the never failing neurosis, and many a case in subsequent attacks show no papules, while the itching remains constant.

Besnier and Doyon:¹⁴ The urticaria may be prodromal or con-

comitant as in other affections, but prurigo cannot be called a transformation or degeneration of urticaria.

Crocker¹⁵ is inclined to regard the papules as secondary.

Anatomy.—The pathological anatomy of the cutaneous tissues was not sufficiently advanced at the time Hebra first described prurigo, to make any opinion upon this point then held of especial value, but it is evident that he did not recognize any marked differences between the nature of the papule in this and in other inflammatory dermatoses, but the views of modern observers concerning the tissue-changes it presents are very diverse.

Koposi¹⁶ says the papules show a moderate cell-infiltration and serous exudation of the papillary layer and rete, just as those of eczema papulosum.

Caspary¹⁷ says it is a change in the stratum spinosum, a hyperacanthosis, all the tissues of the corium remaining normal.

Riehl⁸: The papules present the appearance of acute inflammatory changes in the papillary layer without modifications of the epidermis.

Auspitz¹⁸: The papules are the result of chronic spasm of the arrectores pilorum, a persistent cutis anserina.

Leloir¹⁸: It is a sort of cystic cavity developed within the Malpighian layer, containing a clear fluid.

Crocker¹⁸: The papules are inflammatory, but are not characteristic anatomically.

Pathology.—And so, too, the opinions hazarded as to the pathology, or essential nature of the disease by writers, differ widely. Of course, they are purely theoretical. Thus we find the following conjectures:

A pruritus.

Sensibilitäts-Neurose.

Motilitäts-Neurose.

Diathese prurigineuse.

Neurodermite.

Lymphatism—arthritism—nervoisme.

Vasomotorische Transudation.

Tropho-neurosis.

A discrasy.

The frankest opinion I find expressed is: pathology unknown.

And now what conclusions may we fairly draw from all this mass of discordant views with regard to what constitutes the essential elements of a disease? We find wide differences of opinion held by accomplished dermatologists concerning the primary manifestations

and their mutual relations upon the anatomical character of the so-called characteristic lesion or lesions; and upon their pathological significance; deviations from the Hebra standard in point of the parts affected and course of the disease; marked variations in type and prevalence in different countries and nationalities. And what features remain of so stable a character, so invariably and universally recognized, that upon them we may base the definition of an independent dermatosis?

I cannot go farther than accept the existence of a condition of early childhood, allied to pruritus and urticaria in its visible manifestations, and not to be positively distinguished from them in its first stages, often becoming in certain parts of the world a chronic affection due to some inexplicable national cutaneous traits, or inherent customs of living, a condition which certainly lacks many of the essential elements of individuality.

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A FAVUS-LIKE ERUPTION OF THE ORAL MUCOUS
MEMBRANE, CAUSED BY THE ASPERGILLUS
NIGRESCENS.¹

By JAMES MCF. WINFIELD, M.D.,

Brooklyn, N. Y.

ON November 28, 1895, Dr. William Browning of Brooklyn, referred the following case to me for diagnosis. Patient was a well-nourished woman, aged twenty-seven years, native of Brooklyn, personal history good. She never had any serious illness. Mother, brothers, and sisters are living, and are strong, healthy people. Her father died several years ago of phthisis. The patient, however, showed no evidences of any hereditary taint, such as strumous glands and the like. About two weeks before consulting me the patient noticed, what she called "a small ulcer," situated on the roof of the mouth directly in the middle line, about half-way between the incisors and the soft palate. Supposing this to be an ordinary "canker sore," paid but little attention to it. There was no pain nor discomfort, except when she had any hard substance in the mouth, as, for instance, bread-crust; the hard and sharp edges of this, pressing against the elevation caused slight pain. The patch increased in size, and another formed a little in front of the primary one. The patient then consulted Dr. Browning (September 23, 1895, about two weeks after the trouble first appeared). He at first thought it was nothing but a simple stomatitis, due, probably, to some digestive disturbance. She was treated accordingly, but without any benefit. The patch continued to enlarge, and several new ones formed along the margin of the primary lesion. He then put her on a thorough course of antisypilitics, but this treatment also failed to have any good effect. The doctor then, suspecting the trouble to be an inflammation caused by some local parasite, began making various applications, chiefly solutions of bichlorid, carbolic acid, and tincture of io-

¹ On account of the theory that the different forms of fungi are only transitional stages of the same mold, a number of cultures were made from the original ones taken from the oral growth; each had the same characteristics regarding growth, color, etc. Compare-cultures were also made of favus, tricophyton, and saccharomyces albicans. These all differed from each other and from the aspergillus. I am greatly indebted to Dr. E. A. Wilson of the Hoagland laboratory for assisting me in identifying the various molds.

din. About this time the case was referred to me for the purpose of establishing a diagnosis, the attending physician having in mind that it was, perhaps, favus. When first seen by the writer, it presented the following appearance, which is fairly well shown in the accompanying drawing (Fig. 1), for which I am greatly indebted to

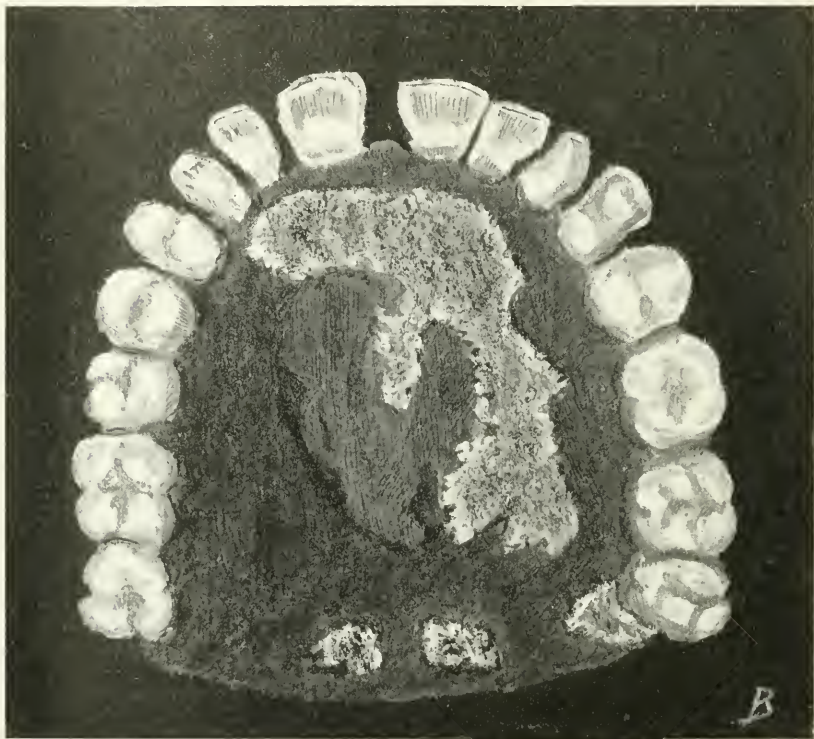
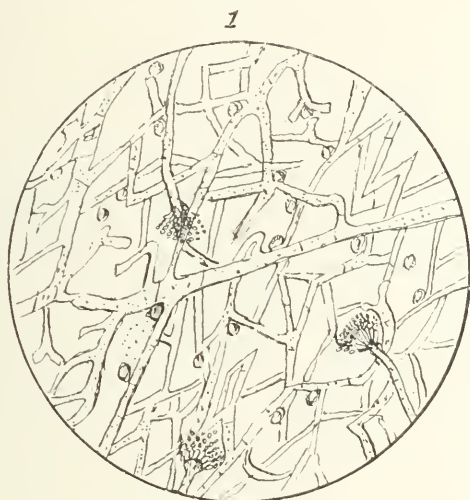


FIG. 1.

Nathan T. Beers, Jr., Stud. Med. On the left side of the roof of the mouth there was an edematous and lumpy patch, occupying a space from just back of the incisor teeth to within one quarter of an inch of the soft palate. There were in addition two round cup-shaped elevations on the soft palate on either side of the median line. Also one of irregular outline back of the left incisor and canine teeth. The patches were more or less covered with a dirty yellow deposit, which was quite firmly attached to the swollen tissue underneath; removal of this membrane produced slight hemorrhage. The color of the recent deposit suggested the sulphur-colored scutula of favus;

but the color of that which had remained undisturbed for a longer period was darker, more of a grayish brown. To the touch the mucous membrane and tissues about the patches seemed swollen and spongy. Scattered over the larger patch there were a number of minute ulcers, which were possibly due to the caustic action of the various applications. The clinical picture was unlike anything before seen, although there were many points of resemblance to favus of the mucous membrane; in other respects it suggested the possibility of a beginning tuberculosis. Owing to the uncertainty of symptoms, history, and strange appearance of the lesion, a positive diagnosis could only be made by the microscope. A small piece of



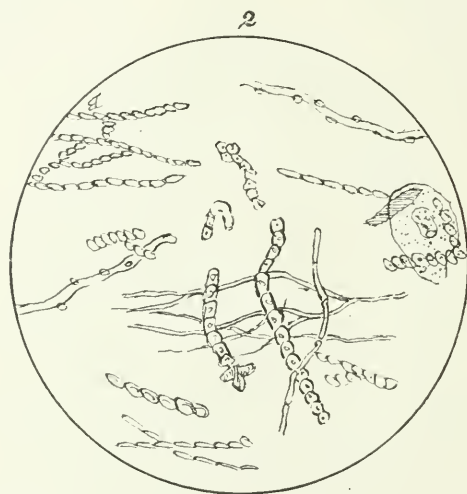
ASPERGILLUS NIGRISCENS

(From case.)

FIG. 2.

the thickened tissue and scrapings from the surface of the patches were procured. The tissue was macerated in glycerin and placed unstained under the microscope. With low power the growth was recognized as a fungus, which on closer inspection was found to differ from the achorion in the following particulars (Figs. 2 and 3). The mycelium net-work was composed of delicate fibers, bearing perpendicularly the fructifying hyphæ, these fibers showed no tendency toward fission as the mycelium of favus does. Scattered over the field there were a number of fruit receptacles and a few loose spores. One of the fields is shown in drawing 1. The manner of fructifying

shows that the fungus did not belong to the oidium, or the naked spore class, but to the ascomycitous genus, the variety, in which the spore is developed within an ascus or receptacle. Some of the scrapings were smeared on agar and blood-serum tubes, the tubes were then plugged, placed in an incubator, at room temperature ; at the end of twelve hours the surface of the serum-tubes was strewn with small white dots. These rapidly grew until the whole surface became covered with a yellowish white mold ; in about thirty-six hours the color of the growth had changed to a grayish-brown. The agar culture grew more slowly, although the same characteristics were ob-



· · ACHORION · SCHÖNLEINI ·

(from Crocker.)

FIG. 3.

served. The diagnosis was then made of a parasitic inflammation caused by the *aspergillus nigrescens*. Treatment naturally was to prevent the plant bearing fruit.

At first, a mildly caustic solution composed of equal parts of resorcin, antipyrin, and creosote was used, which seemed to check the growth of the fungus as long as the weather remained cool, but at the approach of spring it again began to grow. The patient was now referred to me for treatment (May 20, 1896). The appearance of the mouth had changed considerably ; instead of one large patch on the right side, and a small one on the left, the whole

roof of the mouth was thickly studded with irregular-shaped elevations. There were a number of small patches covered with the characteristic membrane on the gums, and the mucous spaces between the teeth. There was also a moldy deposit on the proximal surfaces of some of the teeth. Cultures were again made and the same fungus parasite was identified. As the bichlorid and other antiparasitic treatment had proven unsuccessful, it was decided to try the peroxid of hydrogen, on account of its well-known destructive action on these low forms of life. Accordingly the application of the twenty-five-per-cent. ethereal solution of this compound was begun. Improvement was immediately noticed, the edema became less, the pseudomembrane disappeared, and new patches ceased forming. After about seven weeks treatment the patient was pronounced well. She has, however, been under observation since then, and was last seen September 1st. As yet there has been no return of the trouble. A thorough search through the literature has failed to show a similar case, although many instances are recorded where the aspergillus has been found in the human ear, usually accompanying otorrhea. An interesting point in this case is how the growth became implanted and grew on the healthy mucous membrane of the mouth, where the disturbing action of food and drink, as well as vigorous treatment employed, would be thought to have had an inhibitory effect, but in spite of all this the mold lasted for over eight months, showing only temporary abatement at times. I find that the aurist often experiences the same difficulty in getting rid of the parasite. I was unable to determine satisfactorily how the spores became implanted, although it is fairly probable that it was through the medium of cheese, of which the patient was extremely fond. She ate all kinds, preferring the imported, and that which was strong and more or less moldy. For those interested, I might say, that after a careful hunt for authorities, I find that works on biology and fungi give scant notice to the aspergilli. The best description is found in the definition given in Foster's Medical Dictionary. Roosa and Pomeroy's Text-Books on diseases of the ear also have considerable on this subject.

1273 Bedford Avenue.

Clinical Notes.

A MODIFICATION OF THE URETHROSCOPE.

By J. HENRY DOWD, M.D.,
Buffalo, N. Y.

IN certain cases the endoscope is indispensable for diagnosis and treatment of urethral diseases, both in males and females, and from a trial of several different means of illumination I have pinned my faith to the Otis light. This has one drawback. Without tilting the lamp considerably downward a clear view of the

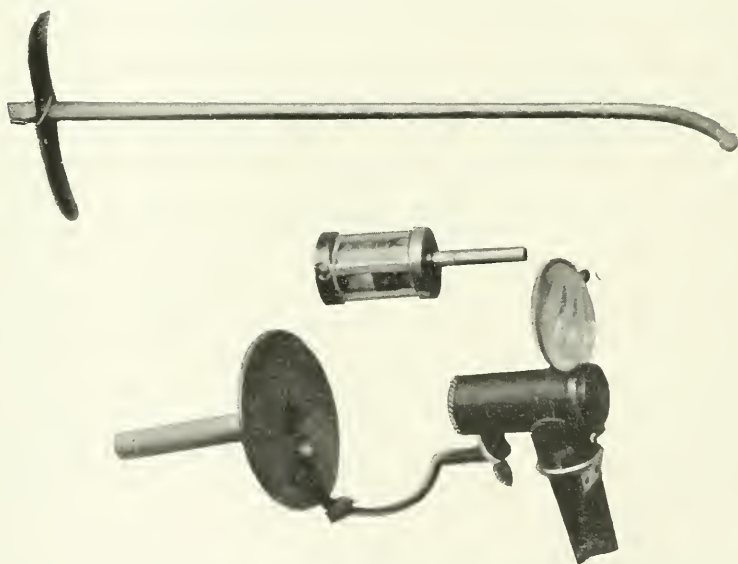


FIG. 4.

field is impossible ; and, even with a moderate tilting, the rays instead of falling directly on the mucous membrane at the distal end of the tube are thrown along the tube's upper surface. This, at times, is very confusing ; the bright silvery shadow being reflected upon the mucous membrane. It occurred to me that, could a compound glass be fitted to the lamp, the tube and lamp might be placed upon a parallel plane, and the field magnified as well. I gave my idea to Dr. Finerty, an oculist of this city, who has, as you can see by the cut, fitted a prism, cemented to whose anterior sur-

face is a lens focused at six inches. The lamp and tube may be placed directly opposite each other, but when looking through the glass the tube is raised about one-half inch, and the picture magnified twice its natural size.

In cases of posterior urethral disease, in which the caput gallinaginis is involved (this being presented to us most forcibly by symptoms of sexual neurasthenia), impotence, prostatitis, etc., I have for some time used ointments of iodid of potassium, silver nitrate, ichthyol and iodoform, as the case calls for. Although some surprisingly favorable results have been obtained, to get this ointment into the syringe has been to me a source of much annoyance. The instruments now on the market have serious defects on account of their clumsiness, impossible sterilization and size of barrel. The syringe I present, and which I have used for some time with satisfaction, is made on the same plan as the small bicycle pump, *i.e.*, the piston moves upward instead of downward, as with other syringes. The top can be removed, and as it is about twice the size of an ordinary hypodermic barrel, its filling is an easy matter. The tip is solid, and can be removed, thus preventing the accumulation of ointment in it, and facilitating the thorough cleansing of the tube.

THREE CASES OF ICHTHYOSIS IN ONE FAMILY.

By WILLIAM FRICK, A.M., M.D.,

Lecturer on Dermatology in the Kansas City Medical College.

Kansas City, Mo.

I WISH to report three cases of ichthyosis occurring in one family, and send photograph of the same. They are three brothers, and their ages are twelve, six and four years, respectively. I first saw them April 12, 1895, and obtained the following history at that time. Their father is living, thirty-four years old, and healthy, except some ulcerations about his rectum. He cannot recall any hereditary disease in his family of any kind whatever. Their mother died at the age of thirty-two years with pulmonary tuberculosis. She was of a tuberculous family, her father, mother, and six brothers having had the same disease. There are four children in this family—the three boys mentioned and a girl eight years old. The girl has been perfectly healthy all her life. Her skin is entirely normal and always has been. The three cases present the same clinical history. At birth they seemed quite healthy with an entirely normal skin. The first departure from the normal,

the father thinks, was between the ages of four and six months. The first thing noticed was a roughness of the skin, with fine scale formation. The scales increase in size and thickness as the boys grew older. The only difference in clinical appearance now between the three is the larger, thicker scales in the oldest boy. The boys seem fairly healthy, and reasonably intelligent. The disease covers practically the entire skin, a small surface between the shoulders in



FIG. 5.

each case is all that escapes. Some parts are more thickly covered than others. The photograph of the leg is of the oldest boy (see cut), and shows the scale-formation better than any other part. In the summer, when sweating is free, the scales clear off to some extent, and the boys think themselves better. The use of vaselin daily, followed by soap and water, accomplishes the same end, but no remedial agent seems to produce a permanent improvement.

Society Transactions.

INTERNATIONAL CONGRESS OF DERMATOLOGY AND SYPHILOGRAPHY.

THIRD MEETING HELD AT LONDON, AUGUST 4, 5, 6, 7, 8, 1896.

The Congress was held in the Examination Hall of the Royal College of Physicians and Surgeons, under the presidency of Mr. Jonathan Hutchinson. The program of the meeting has already appeared in these pages. Aside from the interest attaching to the prearranged deliberations, much was excited by the clinical and museum-features gathered by the executive committee of London medical men. Both exhibits were exceptionally fine, and set a high standard for future congresses. The members were entertained socially, on all sides, receptions and dinners, both public and private.

The following vice-presidents were nominated by acclamation to direct the sittings: Kaposi, Besnier, Anderson, Walter Smith, Haslund, Hutchinson, Schwimmer, Duckworth, Neisser, MacCormac, Unna, Payne, Petersen, Shillitoe, Jameison, Campana, White, Boeck, Bulkeley, G. H. Fox, Hyde, Hallopeau, Veiel, De Galotz, Janowsky, Tarnowsky, etc. The next congress will be held in Paris, in 1900, the Exposition year, Berlin and New York having been withdrawn by their proposers. Dr. Ernest Besnier was elected president. (In view of the fact that the proceedings will be accessible in complete form before long, only a brief *résumé* will be given here.)

At eleven o'clock, August 4th, the secretary-general, Dr. Pringle, to whom more than any one man the success of the meeting is due, opened it with his report. Mr. Hutchinson followed with the President's address, in which he reviewed the progress of the study of dermatology everywhere, the museums, societies, and publications devoted to its development. After these generalities, he took up the relation of lupus to tuberculosis, and wound up with an exposition of his personal notions regarding dermatological nomenclature. After the first day the deliberations were carried on in two sections, devoted to syphilis and dermatology, in each of which special communications were in order.

The first afternoon session was given up to a debate on the question of

Prurigo.

DR. ERNEST BESNIER (Paris). A full abstract of his paper will be found in another place in this issue.

DR. JAMES C. WHITE (BOSTON). His paper, complete, appears on page 2.

DR. J. F. PAYNE (London). The author stated the distinction between prurigo and pruritis; the former a disease, the latter a symptom only, a sensation which occasions scratching by means of cerebral excitation. At bottom, scratching is probably a reflex act, performed with the object of getting rid of skin parasites, the earliest cause of pruritus. A profound affection of the cerebral centers (insanity) may prevent the production of a symptomatic pruritus, and the skin is not scratched. In prurigo, besides pruritus, there is a papulo-urticarial eruption, which does not always precede the itching. The papules are found in winter prurigo and lichen urticatus, the latter allied to prurigo, but having nothing to do with urticaria. True prurigo is rare in London, not incurable, and in mild cases may disappear spontaneously. It begins with the papule, or pruritus. Severe cases are those in which the brain, by a vicious circle of scratching and excitability, is kept in a continuous condition of super-excitation from infancy. The disease is seen in all classes, not alone in the poor. Prurigo is caused by an instability of the sensory nervous system, as chorea is of the motor.

Discussion.—DR. TOUTON (Wiesbaden). It is impossible to tell whether pruritus or eruption is the primitive phenomenon. The disease is clearly defined clinically. There are adult affections which resemble it, and in them pruritis is often the earliest symptom, apparently, at least. A circumscribed pruritus may persist a long time without cutaneous alterations, eczematization, pyogenic infection, etc. These cases, whatever they are called, all present a certain relationship with the prurigo of Hebra.

DR. MCCALL ANDERSON (Glasgow). Stropulus infantum is a true urticaria, unrelated to prurigo, probably of nervous origin, favored by defective hygiene and inherited predisposition. The mass of diverse affections which Besnier unites under prurigo are "pruriginoid diseases," whose true nature is often shown by the localization of their lesions.

DR. HENRI FEULARD (Paris). From a study of 1200 cases of skin-disease in infants (74 of prurigo) the conclusion is reached that the term prurigo covers all the affections in which the same eruptive elements occur. Itching predominates in all; the form of eruption varies with the skin reaction. The great majority are due to a com-

mon cause as well, intoxication, oftenest alimentary. By means of laxatives, intestinal antiseptics, and proper regulation of diet in infancy, continued for months or years, prurigo Hebrae may often be removed in infancy before it becomes, by cutaneous and nervous alterations, incurable.

DR. JADASSOHN (Breslau). Children attacked with Hebra's prurigo are often cured in hospitals, the disease returning after going out, showing that diet plays a *rôle* in its etiology. The presence of eosinophil cells here is no more characteristic than in other morbid conditions.

DR. JANOWSKY (Prague). An experience of 600 cases enables him to say that pruritus is not the first symptom, but is coincident with the appearance of the papule. No toxidermia has been shown in his researches, no indol or urea in the urine, no eosinophilia.

DR. COLCOTT FOX (London). Prurigo may be differentiated from lichen urticatus by two features: He has never seen strophulus merged into prurigo, and prurigo has begun without an initial urticarial stage.

DR. P. G. UNNA (Hamburg). Histologically, the necrosis of the epithelium of the hair-follicle traversing the lesion is characteristic. Pruritus may precede lichenization, but microscopic changes may antedate that. Scratching produces the papules; if it is prevented, there is no lichenization, and necrosis is the only lesion.

Etiology and Varieties of Keratosis.

DR. UNNA (Hamburg). In normal processes of keratinization only the periphery of the cell undergoes this alteration, nucleus, keratohyalin, and eleidin having nothing to do with it. The keratin so formed differs from protoplasm in containing more sulphur, and producing, in course of decomposition, more tyrosin. The change is affected in normal protoplasm by the sulphur or other substance being brought through the lymph-channels to the outer epidermic layers. The transformation may, in fact, be accomplished artificially.

Pathologically there are the processes of keratinization, represented clinically by callus, psoriasis, and ichthyosis. The amount of keratin in these diseases bears no relation to the hyperkeratosis seen macroscopically. This form of keratinization is, like the normal, confined to the periphery of the cells, the differences in keratotic affections being dependent on the thickness of the cell-processes and size of the meshes of the intracellular horny net-work. The amount of thickening depends entirely on the number of cells

affected. Where the cornification is very great, as in ichthyosis, the superficial cell-markings constitute a phenomenon of great importance in the study of these changes.

DR. H. G. BROOKE (Manchester) took up the subject from a clinical point of view, and formulated a classification of the keratoses.

DR. DUBREUILH (Bordeaux) gave a classification of the circumscribed keratoses including in it:

1. The diseases localized regionally, as on the palms and soles.
2. Those confined to the neighborhood of the appendages, hairs, sweat-glands, and nails.
3. Those which constitute circumscribed lesions not localized like the previous classes, but having a predilection for certain areas of the body.

The author then discussed hyperkeratoses (1) of traumatic origin, such as clavus, whose anatomy he reviewed; (2) of congenital origin, *e. g.*, the keratotic naevus. Most cases of ichthyosis, hystrix, and cutaneous horn should be classed in this division. (3) The papillary hyperkeratoses, such as verruca. In speaking of the relations of the papillary layer to the epidermis, the latter was called the parenchyma of the organ, the former furnishing its interstitial tissue and vascular supply. (4) Precancerous keratoses comprising (a) senile cutaneous horns, (b) senile keratoma, the greasy crusts often seen on the face, hands, back, and chest of old people, (c) xeroderma pigmentosum, (d) arsenical verrucoid keratosis, (e and f) chimney-sweep's and tar-worker's cancer, (g) leucokeratoses affecting the mucous membranes. (5) Hyperkeratoses of dermic origin. The examples given of this form were angiokeratoma and hyperkeratosis consequent upon inflammation.

Syphilitic Reinfection.

MESSRS. ALFRED COOPER and EDWARD COTTERELL (London) opened the discussion with a paper in which these conditions were laid down as necessary before the case can be admitted.

(1) A previous attack of syphilis, its history taken not from the patient's account, but from the physician who attended him. (2) A second infection following the usual course. The initial lesion must be followed by secondary symptoms, however slight. The authors believe that immunity acquired in the first attack may be lost, and that reinfection is possible. Many published examples must be taken *cum grano salis*. Mercury, properly used, will cure syphilis, as proved by reinfection. Hereditary syphilis, as a rule, confers immunity.

DR. FITZGIBBON (Dublin). Drawing an analogy between syphilis and the fevers, syphilitic "fever," if uncomplicated by constitutional cachexia or coexistent sepsis, runs a definite course and is followed by a period of immunity, after which infection is again possible. The period of immunity is not an evidence of the presence of the disease any more than is the case with variola. Second attacks of syphilis are apt to be more violent and complicated, as well, by sepsis. From the latter is derived the virulence. The effects of syphilis are not necessarily persistent during life, but elimination is slower and subject to interruptions not seen in the fevers. The majority of syphilitics are completely cured, and proofs are not lacking that, after five years, the disease has not only disappeared from the organism, but its protective influence is weakened. A second infection is not, however, indubitable proof of the absolute cure. Experience shows that after three years the syphilitic, with rare exceptions, is free from every sign of his disease, and incapable of transmitting it. Several unpublished cases were reviewed.

Discussion.—DR. OGILVIE (London). One case, thoroughly authenticated, is better than sterile discussion. He related the case of a physician who suffered from two typical attacks, separated by an interval of two years.

DR. DRYSDALE (London) believes reinfection possible, because it is the rule in almost all virulent diseases that reinfection may occur after several years. He disagrees with Cotterell, and thinks a cure is best proven by health in the subject and ability to procreate sound offspring; but it is hardly certain in any case.

MR. HUTCHINSON (London) remarked that he had published fifty-four cases of syphilitic reinfection in his *Archives of Surgery*. Of these, thirty-four seem to him incontestable.

Relations Between Tuberculosis and Diseases of the Skin Other Than Lupus Vulgaris.

DR. JAMES NEVINS HYDE (Chicago). There may be a primary and secondary infection of the skin by the tubercle bacillus, as well as an auto-infection. Clinical forms of the disease are caused by greater or smaller numbers of the organisms in the tissues. These the author divides into three classes: (a) lesions due to tuberculous infection, (b) lesions in which the bacillus has not been demonstrated, but in which there is presumptive evidence of its presence, (c) dermatoses due indirectly to tuberculosis of other organs.

In the first are classed, (1) anatomical tubercle, (2) tuberculosis verrucosa, (3) tuber. papillomatosa, (4) fibromatosis, (5) tuberculous

elephantiasis, (6) ulcerative tuberculosis, (7) ulcerative gummatous tuberculosis, (8) tuberculous lymphangitis, (9) serpiginous tuberculosis, (10) fungous tuberculosis, (11) nodular, atrophic tuberculosis. In the second class, (1) lupus erythematosus, with certain restrictions, the sum of which is that a connection between the two is possible, (2) *erythème induré des scrofuleux*, (3) lichen scrofulosorum, (4) suppurative acute tuberculosis, (5) a group of acneiform, sycosiform, and follicular diseases, of which tuberculosis may be the cause, (6) keloid, (7) chancroid, complicated by tuberculosis. The third division comprises, (1) certain eczematoid lesions, (2) erythema pernio, (3) exceptional forms of erythema multiforme, (4) certain varieties of melanoderma, (5) purpura of cachexia, (6) some of the drug eruptions.

DR. HALLOPEAU (Paris). Four facts permit affirmation of the tubercular character of a lesion, (1) the possibility of transmission by inoculation, (2) the presence of bacilli, (3) intra-inoculations, *e. g.*, lichen scrofulosorum, a dermatosis resulting from proliferation of tuberculous lesions, (4) the appearance of eruptions like lichen scrofulosorum under tuberculin. No one of these is a *sine qua non*, nor do they constitute all the points of diagnosis. The varieties of the disease are produced by the influence exerted on the lesion by the complex structure of the skin itself, by personal idiosyncrasy, by age, and finally by the form under which the infectious agent acts, the bacillary, the zooglœic (lupus erythematosus), and the pathogenic toxin. The dermatoses due to toxins have these common characters: they occur in the tuberculous, are not destructive, are not hetero-inoculable, and yield ordinarily easily to treatment. There are forms of mixed origin, also. These pathogenic divisions correspond very closely, both in themselves and in the clinical types grouped under them, with those of Hyde. Omitting a few, and transferring one or two, they are practically identical. Like Hyde, Hallopeau seems to have a belief in a tuberculous eczema. Neither writer presents new evidence of the tuberculous origin of erythematous lupus.

DR. RADCLIFFE CROCKER (London). Beside the diseases due directly to the presence of the tubercle bacillus, there are certain others which find a soil favorable to their development in persons predisposed to tuberculosis. This idiosyncrasy is clinically called scrofula; its manifestations, adenitis, bone disease, etc., are familiar.

Discussion.—DR. JADASSOHN (Breslau). The relation of the pityriasis rubra of Hebra, as well as of lupus erythematosus to tuberculosis, is not proved. There is merely a coincidence of the

two in a certain number of cases. The acute erythematous lupus of Kaposi is, curiously, very often combined with tuberculosis. The reporter has, however, seen one case without such a condition.

DR. AUDRY (Toulouse), recognizes three classes: where the lesions are tuberculous, where they are connected with visceral lesions, and where the cachexia furnishes the basis of development. Dermatoses, independent of the disease, may lead to tubercle infection. Every dermatitis of long standing, by enfeeblement of the organism, perhaps by multiplication of the modes of entrance, may favor its appearance.

Lichen Scrofulosorum.

DR. CELSO PELLIZARRI (Florence). The disease usually lasts for years. It occurs in the tuberculous, and the toxins from the foci of disease probably determine the lichen outbreaks. It may, in time, persist and change its form to a suppurative perifolliculitis. In these cases, the toxins prepare the ground for the entrance of Koch's bacilli, an explanation of the controversy over the latter's presence in lichen scrofulosorum. The author succeeded in producing tuberculosis in a guinea-pig from such a case.

DR. JADASSOHN found in nineteen cases of typical lichen scrofulosorum fourteen cases associated with tuberculosis, and only one in which no such disease could be found. He agrees with the Vienna school and Hallopeau, that the dermatosis is non-bacillary. It is a disease of the tuberculous, not due to a cachexia. He has never found bacilli, but the histological characters are practically identical with those of true tuberculosis. In sixteen cases treated with tuberculin fourteen reacted typically; nine inoculation experiments produced no result. He believes that there are latent lesions in the skin of these patients, for he has succeeded in making them visible by the tuberculin reaction.

PROF. KAPOSI. The clinical description given long ago by Hebra and the presence of tuberculous lesions are the only positive diagnostic points in the history of this lichen. Tuberculosis is always present, but there is nothing to prove that lichen scrofulosorum is a manifestation of the disease.

The Duration of the Contagious Period of Syphilis.

DR. HUTCHINSON (London). Assuming the admission that during the primary and secondary periods of syphilis the blood and inflammatory secretions contain the specific virus, the question is, at what period do these fluids cease to contain it and to be capable of trans-

mitting the disease? It is important to know when the contagion is no longer transmissible to offspring. Cases of transmission after long periods are undoubtedly to be found, but the duration of contagiousness is rarely more than two years, may even be one. The virulence, the abundance of the germs perhaps, and the probability of contagion are far less, certainly in the latter part of the secondary period than during the first. Suspicion of transmission is excessively rare in the third stage. Cases were related showing the exceptions to the propositions laid down.

DR. CAMPANA (Rome). There is no certainty as to the duration of this period. It persists as long as lesions show themselves, which have no tendency to undergo caseation, and which are of ordinary inflammatory character. As gummata may occur with early parenchymatous inflammations, infection may occur even in the presence of caseation. The real period of contagion is that of transmissibility. Its length may be determined by treatment, and rarely covers more than three years.

DR. LASSAR (Berlin). The infective power of syphilis diminishes with the duration of the disease, but the disease can be transmitted as long as its symptoms are manifested. Late lesions, experience shows, are commonly non-contagious, and the reason for this is their localization; although the fact should not be lost sight of that, as in lepra and tuberculosis, there are circumstances which facilitate or prevent infection. The question of the contagiousness of mucous patches was long undecided; that of late lesions may be cleared up in a similar way. From a theoretical point of view, the problem of the period of contagion brings up the interesting question whether there is a single process of infection or a metaplasia of the morbid cause.

DR. FEULARD (Paris). The contagious period of syphilis is essentially variable in different subjects, but current opinion estimates it as between three and four years, during which time its accidents appear, and marriage should be forbidden. A certain number of facts, happily rare, prove that transmission is possible even after ten years. This habitually takes place in the course of syphilis which has frequently relapsed; it may, however, occur where no accident has appeared for a long time. The contagious lesion is usually a simple erosion. The genital mucous membranes play a part in late transmission, but the buccal membrane is the source of infection in a third of the cases. Tobacco-smoking is the most important cause of the mouth lesions, and plays a manifest part in prolonging the duration of the contagious period. Previous treat-

ment influences these cases little. A place should be reserved in prognosis for the possibility of later contagion, which cannot be scientifically foreseen.

Discussion.—DR. WICKHAM (Paris). Contagion is of long duration when the lesions are buccal. A fissured leucoplasia may be the source of infection after many years. Opinion as to marriage in such a case should be very guarded.

DR. TARNOWSKY (St. Petersburg). In 1000 cases under observation for 5 years 802 patients presented condylomatous symptoms; after the first 5 years, 167; after 10, 26; after 15, 5. Of 14 cases infection took place after 5, 6, 9, 10 and, in one case, 15 years. The number of years elapsing after the first accident has no influence on the question, for infection may occur as long as secondary symptoms are present.

DR. BLASCHKO (Berlin). Theoretically, the length of the period depends on the presence of the bacillus, and cannot be fixed until it is discovered. The duration of contagiousness is not the same as of transmissibility; the two depend on the localization of the poison.

(*To be continued.*)

NEW YORK DERMATOLOGICAL SOCIETY.

TWO HUNDRED AND FIFTY-FOURTH REGULAR MEETING, HELD ON
TUESDAY EVENING, SEPTEMBER 22, 1896.

DR. J. A. FORDYCE, *President, in the Chair.*

A Case of a Peculiar Affection of the Lips.—Presented by DR. ALLEN.

The case was considered by the reporter an example of the affection described by Dr. Fordyce as a "Peculiar Affection of the Mucous Membrane of the Lips and Mouth." Dr. Fordyce read a paper on this subject at the recent meeting of the American Dermatological Association at Hot Springs, Va. Dr. Allen said that in discussing this paper he had expressed the opinion that the condition described by the author was quite common, and that he had observed a number of cases, although he had never been asked to prescribe for it. The very first patient he saw on his return home from the meeting was a young man who had these milium-like bodies upon the vermilion border in the lip. The patient had applied an acid upon one side to rid himself of the spots, and as a consequence had a whitish cicatrix in this region. The lesions appeared to be in every respect similar to those described by Dr. Fordyce.

DR. LUSTGARTEN said that Dr. Allen's case did not impress him as being identical with the one presented by Dr. Fordyce last spring and recently described in his paper. The lesions in Dr. Allen's case are not quite so yellow, they are more regular in outline, and more superficial. The speaker said he agreed with Dr. Allen, however, that this disease is not rare, although he had never before seen it described. He has observed a number of cases, some of them even more pronounced than the one shown by Dr. Fordyce.

DR. FORDYCE said that since writing his paper he had seen about half-a-dozen similar cases, although less pronounced than the one presented to the Society. In one of the cases the lower lip was involved. In two or three other cases the condition was associated with seborrheal eczema of the scalp. Dr. Allen's case, he thought, was similar to his own.

Paget's Disease.—DR. A. R. ROBINSON showed a hardened specimen removed from a case of Paget's disease of the breast. One curious feature about the case was that there was no apparent hyperplastic condition of the epithelium present, the lesion not being at all elevated above the margin of the surrounding skin.

DR. FORDYCE said that at the recent meeting of the American Dermatological Association the pathology of Paget's disease came up for discussion, and the question arose whether there were any cancerous changes in the skin itself, or whether the malignant disease was confined to the glandular tissues.

DR. PIFFARD said he had examined the skin in cases of Paget's disease, looking most carefully for the so-called coccidia, but without success, nor were there any pearls indicating an epitheliomatous process.

DR. LUSTGARTEN said he had never examined any of these lesions microscopically, but from the clinical features and the published reports he was inclined to believe that there is an epitheliomatous process starting in the skin and extending later to the milk glands and ducts.

DR. GEORGE T. ELLIOT said that speaking solely from a clinical standpoint, all cases of Paget's disease developed carcinoma of the gland at various periods after the appearance of the cutaneous lesion. Under these circumstances it seemed to him that there is a strict relationship between the two, and that we first have to deal with a malignant disease of the skin, and later of the gland ducts. As to the presence of an epitheliomatous process in the skin in these cases, if, as Dr. Piffard asserted, there can be no epithelioma without the formation of pearls, then the existence of such a process there must

be denied; if, however, we may have an epithelioma without the formation of pearls, then the presence of such a process in these cases can be asserted. Dr. Elliot said he held the latter view.

DR. ROBINSON said he had thus far not made a microscopical examination of the specimen in his possession. The early stage of the disease would not show changes which could be recognized as an epithelioma. The speaker said he agreed with Dr. Elliot that it is not necessary in every case of epithelioma to demonstrate the presence of pearls. The formation of these bodies depends on the kind of epithelium from which the disease epithelioma has sprung.

DR. FORDYCE expressed the opinion that in Paget's disease there is no epitheliomatous process in the skin. He was inclined to think that the primary changes occurred in the epidermic cells, preventing the formation of normal horny tissue, and subsequently followed by malignant disease in the milk ducts and glandular tissue.

Report of Cases Presented at Previous Meetings.—DR. LUSTGARTEN reported that his case of diffuse lenticular carcinoma of the skin had died. The autopsy revealed carcinoma of the rectum and also of the stomach, probably metastatic. A microscopic examination of the skin-lesions verified the diagnosis.

DR. ROBINSON reported that his case of generalized lichen planus in a colored woman had recovered completely after two months' treatment. Internally, he gave her large doses of arsenic, with some colchicum, at the same time regulating the diet, giving such kinds of food as he would in a case of rheumatism.

DR. LUSTGARTEN said that in a case of lichen planus under his care he had tried the method of treatment recommended by Dr. Taylor, namely, the internal use of potassium chlorate and dilute nitric acid, with very unsatisfactory results.

DR. FOX said that at the April meeting of the Society (JOUR. OF CUTANEOUS AND GENITO-URINARY DIS., September, 1896) he presented a case of numerous minute angiomas of the face. The patient was a girl, with a number of bright red lesions on the cheeks, and whitish lesions on the forehead. The speaker said that at the meeting of the International Dermatological Congress recently held in London, several similar cases were presented under the name of adenoma sebaceum. He was inclined to think the condition was more frequently met with in England than in this country.

DR. MORROW said that at the May meeting of the Society he had presented, for Dr. Lapowski, a patient with the diagnosis of mycosis fungoides in the premycotic stage. Since then some of the lesions

have undergone infiltration, becoming raised and assuming a fungoid appearance.

Dr. Fox presented a specimen of Balatin, saying that his attention had been called to this article over a year ago, and experimentation with it had convinced him that it might be used to great advantage in the topical treatment of skin diseases.

According to the statement made, this is a natural product of a South American tree imported in the form of a white creamy liquid, which dries quickly upon exposure to the air, and forms a pliable, translucent, impermeable coating upon the skin. Unlike collodion and traumaticin, balatin is perfectly bland and unirritating, even when applied to a raw or inflamed surface. It is miscible with water, but coagulates when added to alcohol or chloroform, and will hold in solution or suspension the drugs commonly used in the treatment of skin disease. The peculiar odor of the product is evidently due to some acetous fermentation which has taken place, and which might undoubtedly be prevented by the addition of an antiseptic at the time when the natives draw the milky sap from the trees. Even now it can be readily disguised or counteracted by the addition of an alkali.

Dr. Fox said that the value of balatin as a simple protective coating was evident at a glance, and that its superiority to gelatin-preparations could be demonstrated by comparative tests. He had used it both plain and as a vehicle for various medicaments, and had found it of service in the treatment of acute and chronic eczema, psoriasis, and other affections.

Chancere of the Upper Eyelid.—Reported by Dr. C. W. ALLEN.

The patient was a young man, who, while riding a bicycle, was struck in the face by the twig of a tree underneath which he was passing. He received a slight scratch on the upper lid which undoubtedly became subsequently infected. There was slight induration about the sore, and the ulceration which set in extended to the ciliary margin and deep down into the hair follicles. The ante-audicular glands on one side became enlarged, and a general eruption made its appearance in due course.

Dr. SHERWELL reported a case of dactylitis involving the middle and ring fingers of both hands, in an infant less than two months old. The child also had a syphilitic eruption, but the mother appeared to be perfectly healthy. The speaker inquired as to the frequency of this condition in early life. While he saw no reason that this should not occur as a lesion, in his experience as a clinician, this was the earliest time he had ever noted it.

DR. TAYLOR said it has been clearly demonstrated that there are two forms of dactylitis, namely, the syphilitic and the so-called scrofulous, which, as a rule, is tubercular. The latter form may make its appearance very early in life, and may be a tubercular osteomyelitis. The speaker said he had seen a number of cases of dactylitis of syphilitic origin as early as the third month of life, although such cases are unusual. The more precocious the disease, the greater the number of fingers and phalanges usually involved.

A Case of Dermatitis Venenata.—DR. GEORGE T. JACKSON reported a case of dermatitis venenata from euphorbia. The patient, who had always been very susceptible to ivy-poisoning, recently received a bunch of euphorbia flowers, and soon had a severe attack of dermatitis. She had not been exposed to either form of rhus. It was the first case of the kind that the speaker had met with.

Dermatitis Exfoliativa.—DR. ROBINSON referred to a patient whom he presented some time ago, who had a peculiar eruption which some of the members diagnosed as exfoliative dermatitis, and others as psoriasis. Dr. Levisieur, who was present at that meeting, and who had seen the patient sometime previous to that date, said the eruption then was undoubtedly psoriatic in character. The lesions gradually disappeared and the man remained well until about two months ago, when a well-marked psoriasis again set in. In spite of treatment it has been spreading, and the lesions are again showing the characteristics of an exfoliative dermatitis, and threaten to cover the entire cutaneous surface, as in the previous attack.

DR. P. A. MORROW said that several years ago he presented a patient with a well-marked dermatitis exfoliativa following psoriasis. That patient had had two similar attacks.

DR. GEORGE T. ELLIOT said this same subject came up for discussion several years ago. It has always seemed to him that these cases of so-called dermatitis exfoliativa following psoriasis are not cases of dermatitis exfoliativa in the true sense of the word. Where the eruption has any connection with psoriasis, it probably represents nothing but an acute, diffuse outbreak of that disease. He had seen a large number of cases where the body was almost entirely covered with psoriatic lesions within ten days from the onset of the disease; in other cases the lesions blend, forming a diffuse eruption. In all of these cases the symptoms subside under the usual treatment for psoriasis.

DR. ROBINSON showed a drawing of a patient who had an eruption which in every respect resembled the erythema of scarlet fever; in fact, a diagnosis of scarlet fever was made when the patient was first

seen. About seven months later the patient had an exactly similar attack, and since then she has had at least half a dozen others. The eruption can be produced at will by giving her ten grains of quinin. It is always followed by exfoliation, and the speaker said he regarded dermatitis exfoliativa as a proper name for it until we know more about the different processes causing an inflammatory dermatitis with extensive dry desquamation.

DR. PIFFARD said that in botany and zoology certain generic marks are put down square and plain, and these are never given to anything else; in dermatology, on the contrary, terms are too loosely applied; the term dermatitis exfoliativa, for example, is employed by one man to cover certain affections which another man would not think of including under that title. Every man makes the term as broad as he chooses, and in this way confusion arises.

DR. FOX said he agreed with the statement made by Dr. Piffard, that by employing certain names which attempt to describe a disease we incidentally include many distinct affections. The case reported by Dr. Robinson, while it is without doubt one of exfoliative dermatitis, is not the exfoliative dermatitis described by Wilson. It is simply a congestion of the skin, causing death of the epidermis. In the typical form of dermatitis exfoliativa there is an intense congestion of the skin, followed by pie-crust degeneration. The process is similar to that observed in the pityriasis rubra of Hebra. If this pie-crust formation is chronic and continuous, atrophy of the skin naturally takes place, and then the name pityriasis rubra is applicable.

The speaker said he had seen many cases of acute, generalized psoriasis, but in these the clinical aspect was entirely distinct from exfoliative dermatitis. Occasionally, however, we see a case of psoriasis in which, within a very short time, general congestion of the body occurs, followed by the formation of large flakes; in such cases recurrences are common. Such a condition is very properly called an exfoliative dermatitis, precisely the same as when it is idiopathic. Whether it follows a psoriasis or not, the eruption is an exfoliative dermatitis, and therefore we should not call it an after-stage of psoriasis, or a clinical form of psoriasis, but a distinct affection, occurring after a psoriasis.

DR. ELLIOT inquired of Dr. Robinson whether he would class his case of scarlatiniform erythema as one of exfoliative dermatitis? Would he employ the latter term as an expression of a clinical appearance which can be produced in certain persons by the most various causes, such as inunctions of mercury, the internal administration of different drugs, septicemia, etc., etc.; that is, would he use

the term irrespective of the etiological and pathological cause of the trouble?

DR. ROBINSON replied that in his opinion it mattered very little whether he called his case one of scarlatiniform erythema or exfoliative dermatitis. So far as the symptoms are concerned, it is a desquamation, and in every instance we must try to discover its cause. If it is due to quinin it is an exfoliative dermatitis from quinin.

DR. ELLIOT said that while practically, in dealing with patients, it made little difference what term we applied to such an eruption, yet scientifically it did make a difference.

DR. PIFFARD said we must first get a proper definition for our primary terms. For instance, what do we mean by inflammatory? This was originally described as phenomena giving rise to redness, swelling, heat, pain. Of the two terms, scarlatiniform erythema and dermatitis exfoliativa, one would indicate an inflammatory condition and the other a condition that was not inflammatory.

DR. ELLIOT said that outside of erythema simplex, the histological differences between an erythema and a dermatitis are very slight.

DR. FORDYCE said we should have a definite clinical term for such a group of symptoms as we see in exfoliative dermatitis.

DR. ELLIOT said that several years ago he presented to the Society a patient with an eruption which he had then designated erythrodermia, not being able to catalogue definitely the case. At that time he was inclined to think that it would prove to be one of pityriasis rubra (Hebra), and two years later, when he again presented the patient, the symptoms of that disease were well marked. The man died last February and the *post-mortem* revealed a general tuberculosis, involving the lungs, liver, intestines, etc. The tuberculosis was probably secondary, as the man had had the eruption for many years without showing any evidences of that disease. When he was presented to the Society he had enlarged glands in all parts of the body. He also had growths in various parts of the body, some of which were excised and found to be lipomata. He reported the case at present on account of the tubercular development, a feature which has been observed in the majority of cases of the disease.

DR. PIFFARD said it is curious that Hebra, who was the first to describe pityriasis rubra with any clearness, should have overlooked the fact that it bore any connection with tuberculosis, if such were the case.

Case of Chancre of the Cheek.—Reported by DR. ALLEN.

The patient had a number of in-growing hairs on the cheek which were pulled out by his barber with tweezers. The spot involved be-

came so painful and inflamed that the patient saw a number of physicians regarding it, who all seemed to agree that it was a sycosis and advised epilation. This proved to be so painful that one physician injected cocain so that he could continue this line of treatment. A spot about the size of a twenty-five-cent piece was epilated. When the man returned to New York he came under Dr. Allen's observation, who recognized the lesion as a chancre of the cheek, the probable source of infection being an infected instrument employed by the barber. The glands beneath the jaw were enormously enlarged. He subsequently developed a syphilitic eruption, mucous patches, and ulceration of one tonsil.

DR. R. W. TAYLOR said the case reported by Dr. Allen was susceptible to another interpretation. It may have been that the barber produced a follicular lesion which later was inoculated with syphilitic material by the patient himself. Such instances are not uncommon. Three or four years ago he saw a man, who, while in Buffalo with a number of friends, went out to have a good time. They accordingly procured some concentrated tincture of capsicum, with which they covered their fingers, and then visited a house of prostitution and fondled the colored female inmates. The girls raised a great outcry, when this man and his friends lost no time in making their escape from the house. While running he happened to scratch an itching pimple on his chin with his finger-nail. In due time a typical chancre of the chin developed. Dr. Taylor also reported some cases of chancre of the upper lip. In speaking of chancres in this location, he said they are more frequently met with on the lower than on the upper lip.

DR. ELLIOT said he had seen only a few chancres on the upper lip. In the majority of cases the lesion was on the lower lip.

DR. ALLEN said that within recent years he had observed cases in which the initial lesion of syphilis was located on the upper lip. Previous to that time, in all of his lip-cases, so far as he remembered, the chancre was on the lower lip.

Selections.

GENITO-URINARY DISEASES AND SYPHILIS.

A New Origin of Urethral Fistulæ. Drs. TREKAKI AND VON EICHSTORFF of Alexandria (*Ann. des mal. des org. gen. urin.*, 1896, p. 769).

The authors make an interesting contribution to the study of the Bilharzia hematobia as a cause of urethral fistula, detailing the histories of seven cases. The fact has already been observed by Harrison (*Leçons cliniques sur les mal. des vices urin.*, 1887, p. 254) and by Belleli (*Gaz. degli ospitali*, p. 1 to 5, 1896) that this worm, or its ova, may give rise to this trouble.

The cause of this disease, discovered in 1851 by Bilharz, consists of a male and female worm. The male is 11 to 14 mm. in length, and 1 mm. in thickness; the female is one-third larger. First discovered in the blood of the portal vein; they have also been discovered in the blood and tissue of the kidney, bladder, prostate, urethra, and peri-urethral tissues. The egg measures twelve to fourteen times the size of a leucocyte, oval in shape, with a spine at one extremity. The embryo, more frequently enclosed in an egg, may also occur free.

The eggs may be found either free in the bladder, or urethra, or in the thickness of the tissues, and it is generally in the net-work of veins and capillaries of the genito-urinary apparatus that the eggs are deposited, where they may form veritable subcutaneous tumors.

These tumors may form in the peri-urethral tissues in any portion, perineal, scrotal, or in the penis, most frequently in the perineum. In the histories related there had been no occurrence of gonorrhea or syphilis. The usual history in these cases was the formation of a tumor in the perineum, which would become indurated, and their extent distinctly capable of being made out by touch. At some one point they become softened, present fluctuation, and either burst spontaneously or are opened by operation. They discharge a purulent or saniopurulent material, containing the ova or even free embryos, and there is always present a pus-forming staphylococcus. This is followed by a urinary fistula, through which the urine escapes during the act of urination.

Unless operated upon these fistulæ persist, discharging pus and

ova. The abscess formation is generally accompanied by but little pain, and little rise in body temperature.

The disease may be preceded shortly, or even years before, by a history of hematuria, or cystitis.

Unlike fistulæ, consequent upon gonorrheal or traumatic stricture, these are strictly speaking not accompanied by stricture. The tumors may encroach upon the lumen of the canal, narrowing it, but the stream of urine is not impeded, and generally a large sound can be passed into the bladder.

The fistulæ may have one or more cutaneous openings through which the urine flows, more frequently one opening. The cutaneous opening may be capable of admitting a No. 4 or 5 French sound, the fistulous tract is somewhat larger, may admit No. 12, the urethral opening is generally smaller than either. The sinus may be straight or tortuous; when tortuous the internal opening is difficult to find.

Only by operation can these fistulæ be closed; patient is placed in lithotomy position, a staff passed into bladder, and an incision made over the indurated tissues, which are thoroughly cleaned out before opening into the urethra and forming the boutonnière. A perineal drain is used, and the wound is packed. The wound closes in from six weeks to several months. In cutting through the induration, it is found to be hard, cartilaginous, and almost bloodless.

The authors believe the softening to be due to the presence of the staphylococcus.

The disease is most frequently found among the fellahs who inhabit the Delta of the Nile, and in forty per cent. of the cases urinary fistulæ occur. Bilharzia hematodes are seldom found in Europeans inhabiting these regions, and according to the authors urinary fistula as a disease has never been observed among them.

Some Questions on the Theory of the Inheritance of Syphilis.

E. VON DÜRING (*Abstract in Archiv für Derm. u. Syph.*, 1896, p. 460, from *Monatsch. für prakt. Derm.*, Bd. xx, No. 5 and 6).

As an amplification of the work of Kassowitz on the transmission of syphilis, Von Düring takes up the question as to what those conditions are under which the syphilitic contagion is debarred in its transmission into the neighboring vascular system, and why, in certain cases, this hindrance is overcome; and second, in what manner immunity to syphilis takes place without the occurrence of syphilitic disease. Kassowitz in 1884 regarded this question as still lying in a wide field; Von Düring seeks to narrow this field, and gives a *résumé* of the present status of those questions which are essentially under con-

sideration, the theories (*a*) of germinative infection, (*b*) of infection through the placenta, (*c*) of immunity and immunization.

(*A*) *Germinative Infection*.—While it was formerly accepted that a cell, which carried the infecting germ, could not develop, and that the transmission of an infectious disease could only take place in the sense that a predisposition to a new infection could be inherited, we now know from Pasteur that a genuine parasitic infection may be conveyed by the process of generation itself. More recently Mafucci has shown that if a hen's egg is inoculated with tuberculosis, the development of the ovum is not prevented, but the bacillus is taken up by the developing embryo, remains in the same, and after the chicken is hatched, tuberculosis may break out after twenty days incubation. Mafucci further showed that the bacilli, both in the egg albumen, as well as in the embryo itself, were transformed into small granules capable of receiving the stain, this being a quiescent form. These results reveal simply the comprehension of "latency" in hereditary infectious diseases.

(*B*) *Infection through the Placenta*.—The author embraces the results of investigations and clinical experience in the following points: (1) The healthy, physiological placenta does not permit the passage into the fetal blood circulation, either of finely divided foreign bodies incapable of multiplication, or of microorganisms. It forms a complete filter. (2) Microorganisms may, however, attack the placenta, and give rise to emboli, infarcts, hemorrhages, necrosis of epithelium, etc., through which they gain entrance past the barrier. The filter leaks.

(*C*) *Immunity and Immunization*.—(1) Soluble substances, as toxins and antitoxins, may pass from mother to child, or *vice versa*. (2) Active immunity may be acquired by overcoming the infecting disease. This may arise (*a*) through natural resistance of the tissues, or (*b*) in the circulation of a substance (antikörper) capable of neutralizing the tissue-change products of the microorganisms. (3) By the transmission of this substance (antikörper) from an individual actively immune to one not immune. A passive, and under ordinary circumstances temporary, immunity is conferred. (4) A very durable immunity may be acquired by incorporation of the tissue-change products of an infectious disease from intoxication with the toxins. This immunization comes very close to the active immunity. (5) Again, the effect of an infection or an intoxication asserts itself with the elimination of the neutralizing substances (antikörper), or the ceasing of the passive immunity. (6) The neutralizing substances (antikörper) are contained not only in the blood, but also in the

physiological secretions; they may be conveyed to the nursling through the milk, for example, and be able to increase its passive immunity to a high degree and during long continuance. (7) If infection of the mother takes place during pregnancy, then we have possibly any of the intermediate conditions between abortion and infection up to the fully developed fruit possessing passive immunity. The difference in the result is dependent upon severity of the infection (and the formation of the toxin), and upon the physiological, or pathological condition of the placenta.

Clinical Portion.—The author reviews the hypotheses of Finger; (*Archiv für Derm. u. Syph.*, xxii, 1890, p. 331), and of Kasso-witz, and takes up Colles' law, the explanation of which has been the cause of so much strife. The fact that a healthy woman made pregnant by a syphilitic man, may bear a syphilitic child, and yet herself remain free from every symptom of a syphilitic infection, and at the same time be refractory to syphilitic infection, causes some authors to declare her to be sound, while others declare that she has a latent syphilis, and others regard her as immunized. Finger says of this: such a woman behaves toward a syphilitic infection like one who either is latently syphilitic, or is cured of syphilis in the sense that she is actively immunized. Under latency of syphilis we may conceive, according to the author, a state of equilibrium between the virulent parasites present in the body, together with the toxin circulating in the blood, and those substances (*antikörper*), formed either spontaneously or by therapeutic measures (as mercurial administration). A case of syphilis is conceivable in two different ways: (*a*) The parasites, with time, may lose their virulency and die out. Toxin and antitoxin are secreted. Under such a condition a reinfection is possible. (*b*) A cure may be assumed where, after the disappearance of the "*antikörper*," a condition of insusceptibility of the tissues to the poison may be left, so that the active immunity becomes a continuous one. The author regards the occurrence as analogous to the facts related under germinative infection, that the parasite is carried over with the spermatic fluid, either as such, or in the quiescent form, and after successful conception is contained in the ovula. The microbe becomes active during the last three months of pregnancy, and during this time its tissue-change products, the toxins, circulate in the blood of the mother, while the parasites themselves are held back by the healthy, impenetrable placenta. These circulating toxins are the cause of the mother's being refractory to infection. What has happened to the mother? Fournier says she has a latent syphilis; Finger: that she is immunized. The author says that she has

gone through with an "intoxication," and that she is in the same condition as one who has tertiary syphilis, who, for instance, may bring forth healthy children, and at the same time be subject to tertiary accidents, whose infection is cured, but whose "intoxication" continues latent. These mothers are hence in the condition of a latent intoxication or a "tertiary latency." They may suckle their children, with tissues or papules in the mouth, and yet be refractory to the syphilitic infection, and still they may years later present tertiary manifestations. As a consequence of the intoxication in the mother, refractory to infection, we may have a tertiary syphilis—*d'emblée*, or we may have a certain cachexia, though not necessarily. This condition of being "refractory from intoxication" may pass into a real immunity (just as in syphilis by infection, smallpox, typhus, etc.), or into a cure, which, just as syphilis from infection may be followed by a reinfection, so this may be followed by a first "infection."

The fact, that an apparently healthy mother gives birth to a syphilitic child, takes place for the most part when the syphilis of the father has become old, when it is latent. We may conceive that the virulency of the parasite has become attenuated. What then takes place if the virulence of the parasites in the seminal fluid is more intense? It develops more rapidly; the impregnated ovula may become imbedded in the mucous membrane of the uterus, but because of this increased virulence it may quickly die. In such a case, if no barrier-membrane has developed between the parasites and the maternal tissues, sufficient time may elapse before the expulsion of the impregnated ovula for an infection of the mother to take place. Or sufficient time may have elapsed for the formation of the placenta, but this may become diseased and cease to act as a filter, and an infection of the mother takes place (syphilis *par conception*). The author accepts the view of Finger that the infection of the sperm-cell is possible, but not necessarily the only outcome. Therefore, a man with recent syphilis may beget a healthy child, and after the birth of the child, infect the mother, or twins may be born, one syphilitic and the other healthy.

Should the mother become infected after conception, then an infection of the fetus may take place, or the fetus may suffer from an "intoxication" through the tissue-change products circulating in the blood of the mother. All that has been said previously in reference to the intoxication of the mother through the fetus may be found in the reverse direction. The fetus then may have a more or less pronounced immunity to syphilis in consequence of the "intoxication."

This is Profeta's law. Such children may be more or less cachectic, without specific symptoms, or, corresponding to the tertiary symptoms occurring in mothers, we may find tertiary symptoms in the children as sequelæ of the specific intoxication: *syphilis hereditaria tarda*. There are many exceptions to Profeta's law; either the protection afforded by the intoxication is very weak, or it may be lost by the fact that the child receives nourishment from a healthy non-immunized nurse. Therefore it may be that there is no better nurse for a syphilitic child, or for a child refractory to infection from a syphilitic mother, than the child's own mother. These exceptions, however, need not lessen the value of Colles or of Profeta's law. Just as where an animal, which has been insufficiently immunized with anti-diphtherin, may succumb to diphtheritic infection, or show severe symptoms of the infection, so we must conceive these exceptions as a proof of insufficient immunization.

CUTANEOUS DISEASES.

Prurigo. ERNEST BESNIER (*Annales de dermat. et de syph.*, t. vii, Nos. 8-9, 1896).

The author's conclusions are presented in his own words:

1. The pruriginoses which Willan united in the order of papules—strophulus, lichen, prurigo—constitute a natural and normal dermatological group, which the name prurigo group fits perfectly.
2. The term prurigo, accompanied by qualifying adjectives, presents correctly, and without the least ambiguity, all the affections here united. The adoption of that terminology puts an end to the confusion arising from multiplicity of species, forms, and varieties arbitrarily named according to characters exclusively morphological.
3. The name Pruritus, whose signification is a symptom common to many morbid states, cannot indicate a syndrome, and still less serve to denote a disease; it should be kept for symptomatological terminology.
4. The group of prurigos comprises the prurigo of Willan and those of the lichen and strophulus species, since Hebra's time scattered among erythemas, urticarias, eczemas. The majority of them, revised and restudied, are reintegrated with prurigo.
5. The attempt to constitute a new type of prurigo, based on a suppositious specific anatomical character, would continue the confusion in regard to the affections of the same nosological order as prurigo, now scattered through other classes.
6. Several kinds of true prurigos—pruriginous, multiform. chronic dermatitides, with exacerbations—have multiple and com-

mon⁷ lesions, the first of which are lichenization and eczematization. They form a class among prurigos due to diathetic conditions; they constitute one of the most ordinary types of diathetic prurigos.

7. General neurology and dermatological neuropathology are not advanced enough to treat profoundly the question of angioneuroses, neurodermites, applied to the prurigo-theory.

8. Whatever the pathogenic agent governing the production of pruritus and primary or secondary lesions of the skin in the prurigos, the existence of blood changes, direct or indirect, of complex character, present great probabilities. According to this theory, the prurigos would be temporary, intermittent, remittent, permanent toxidermias, or autotoxidermias. Whether it is toxic or toxicin, this irritant, produced in the liquid blood or in the lacunar spaces by secondary reactions, acts on the sensory areas of the cord or its peripheral extremities, and creates, with the pruritus, or in its train, disturbances of circulation and nutrition, which represent the series of primitive parenchymatous lesions.

9. Pruritus, in the prurigos, is prior and superior to the lesions. The autonomous itching of the papule, or of other anatomico-pathological states, is not to be confounded with the local pruritus or the diffuse which surpasses the limits of the area and emanates directly from primitive cord or peripheral irritations, and not from the lesion which is contingent upon it. Pruritus survives the papules; the papules never pruritus.

10. In the prurigos, the direct action of pathogenic conditions tends to produce in the skin a physio-pathological state, a sensory and nutritive disturbance, and, for the acute forms, a more or less increased neuro-vascular tension; but it does not commonly determine, of itself, the lesions of the surface. These lesions, acute, slow, chronic, primary, or secondary, immediate or remote, count among their essential factors traumatic acts of scratching, etc. Conveniently and completely protected against traumatisms of every sort, the skin remains free from lesions of the surface.

Prurigo. L. BROcq (*Annales de dermat. et de syph.*, Nos. 8-9, 1896).

The author concludes that although there are doubts of the specificity of the prurigo papule, and some reserve is to be made on this point, nevertheless this elementary lesion constitutes the chief objective symptom of the prurigo group. In logical consequence, other names should be chosen for the lesions of scratching consecutive to parasitic affections, for neurodermites, and for Besnier's diathetic prurigos. The true prurigos, like the others mentioned, should be

regarded as various modes of reaction of the skin under morbid agent, alimentary intoxication, viciation of the renal function, etc. These causes determine the itching, and the lesion follows traumatism. The lesion may be one of urticaria, prurigo, neurodermitis.

Neurodermitis Chronica Circumscripta. TOUTON (*Archiv für Derm. u. Syph.*, Bd. xxxiii, Hefte 1 and 2, November, 1895).

The author follows Brocq and Jacquet in their efforts to narrow the fields of lichen, prurigo, and eczema, as extended by the Vienna school, and to establish the term "neurodermitis" for certain local lesions due primarily to pruritus. The nervous element plays the largest etiological rôle; "lichenization" and "eczematization" have been coined to express the cutaneous alterations following the traumatism of continuous scratching. Lichen ruber, lichen planus, lichen ruber acuminatus, and lichen scrofulosorum are in no wise interfered with. After reviewing the literature, and giving nine cases of his own, Touton clears away a few of the older terms, making a place for neurodermitis, as follows: Vidal's lichen simplex chronicus is the neurodermitis chronica circumscripta of Brocq; Vidal's lichen simplex acutus and eczema papulatum of the Vienna dermatologists, Vidal's lichen ferox and prurigo Hebra are identical; all are neurodermites. The first form is the only one considered. From Touton's article, symptomatology, histology, and diagnosis will be taken; from Brocq's (*vide infra*), etiology and treatment.

The affection begins with a localized pruritus, followed later by the appearance of patches, usually symmetrical, on the neck, dorsal surface of forearms and wrists; both surfaces of legs and thighs and the lumbar region. The patches are red, marked by secondary scratch lesions, and covered by scales or crusts. The skin is thickened, its lines deepened; it is "lichenified." Itching is most intense at night. The disease resists treatment, is prone to relapse in autumn and winter, and often alternates with rheumatic affections. A patch may have three concentric, ill-defined zones; outer, brown and soft; middle, brown-red and scaly; inner, red, infiltrated, and elevated, often scaly also.

The pars papillaries of the cutis shows round-celled infiltration, and the papillæ are enlarged. Leucocytes infiltrate the stratum mucosum, which is increased in depth and exhibits a tendency to vesicle formation. The process of keratinization is retarded so that there is no thickening of the stratum lucidum or granulosum.

The disease is differentiated from eczema by its chronicity, the long prodromal period of itching, without skin lesions, and always

worse at night; by absence of catarrhal exudation, except as a result of excessive scratching. Neurodermitis resembles somewhat lichen planus, but the characteristic papule is absent, and arsenic has absolutely no effect on it. Prurigo Hebræ begins in infancy as a papulæ urticaria, and is not found in the flexures. The resemblance of the two is striking, if it is granted that prurigo may begin between the fifteenth and twentieth years. The prognosis is better in neurodermitis. Pruritis is the connecting-link in the group. Neurodermitis is a distinct type, characterized by primary local pruritus, with diffuse, consecutive lichenification.

Lichenification and Neurodermitis. L. BROcq (*Ann. de dermat. et de syph.*, t. vii, Nos. 6 and 7, 1896).

Neurodermitis is seen in neuropaths whose system have been shattered by care, grief, etc. Changes of season, especially great heat, determine the crises. Intoxications, alcoholism, drug-habits, nutritive disorders play an important rôle in pathogeny. On the side of predisposing causes, lie the soil, nervousness, arthritism; as determining factors, there are violent emotions, shocks, and intoxications. It may coexist with other eruptions in the same individual. It is especially common in adult women. There are no lesions of the nerve filaments in the affected areas.

Medication consists in:

1. Avoiding all excitants of the nervous system, modifying mode of life, and alimentation.
2. Calming excitability of the nervous system by hydrotherapy, electricity, antipyrin, gelsemium, etc.
3. Applying locally occlusive dressings, plasters, traumaticin, tampons soaked in antipruritics and covered with rubber sheeting, hot or cold applications, adherent ointments containing carbolic, salicylic acids, menthol, guaiacol, etc.

Eosinophil Cells in Dermatitis Herpetiformis. (*Annales de dermat. et de syph.*, t. vii, No. 6, pp. 842-849.)

Darier has set himself to control the researches of Leredde and Perrin relative to the presence in abnormal number of eosinophil cells in this disease, and confirms their results absolutely. The patient had two attacks of erythematobullous eruption, with the features characterizing this form of Duhring's disease. Histological examination showed an edema of the papillary body just underneath the epidermis, which caused the formation of a bulla, raising the entire epidermic layer. The papillary portion showed an infiltration of cells found also about the vessels of the corium. This infiltration

was composed of connective-tissue cells, lymphocytes, and polynuclear leucocytes, among the last a number with eosinophil granules. They are relatively more frequent in the papillary edema, especially in the liquid of the bullæ, some even migrating among the epidermic cells. In the lymph of various vesicles, he found thirty-five to fifty-five eosinophil in one hundred white corpuscles; in the blood, fifteen in one hundred. They were not found in appreciable number in the serum of eczema-vesicles or the bullæ of lepra, although increased in the blood in the latter disease.

Leredde, in the following communication, gives his method of staining the cells in the liquid of the vesicles and bullæ. He has found in the blood a mean of twelve to fifteen eosinophils in one hundred white corpuscles; in the bullæ, thirty-five to ninety-five in one hundred. The objections to their diagnostic importance are (*a*) that they are found increased in the blood in other affections—lepra, leucemia, secondary syphilis, and (*b*) that they exist in the vesicular and bullous lesions of the skin, having been discovered in ecthyma, herpes, and dysidrosis. To the first, the answer may be returned that they are not found in the cutaneous lesions; to the second, that in only one disease, dermatitis herpetiformis, is there seen an excess of eosinophil cells both in the blood and the elements of the eruption. He considers the cases of erythema multiforme in which the combination has occurred as acute attacks of dermatitis herpetiformis. The discovery is of value from a diagnostic point of view, enabling us to eliminate pemphigus and erythema without waiting for successive outbreaks. Finally, the frequency of eosinophilia in microbic diseases, such as syphilis and leprosy, points to a similar hypothesis in dermatitis herpetiformis which remains to be confirmed.

Pathological Anatomy of Psorospermosis. J. DARIER (*Ann. de dermat. et de syph.*, t. vii, No. 5, p. 742).

Apropos of a new case of the disease reported by Hallopeau on page 737 of the same number, Darier gives a revised view of its anatomy, which differs more or less widely from his earlier one. The lesions have a marked predilection for the orifices of the pilosebaceous follicles, but do not always occupy this site, being found about the mouths of the sweat-ducts and in the epidermis itself. Healthy follicles are seen surrounded by morbid areas. When not connected with a follicle, it is proper, as demonstrated by staining methods, to denominate the substance which replaces or infiltrates the horny layer at the borders of the element as "keratoid masses."

These have not the constitution of the stratum corneum; on breaking up, they seem to be composed chiefly of granules—a diagnostic point.

At the border of the lesions is seen, also, another characteristic feature—fissure of the mucous layer. It is disintegrated by rupture of the filaments of union, fissured and crossed by lacuna; its cells are small, deformed, rarely in process of karyokinesis, and either accumulate in masses or float in a space (vesiculette) which seems to contain liquid. These fissure or cavities are not caused mechanically, but result from irritation caused by pressure of the keratoid masses. The granular layer is interrupted in the lesions. The eleidin, instead of occupying the cells, is absent, or more often appears isolated, or gathered into little groups in the upper part of the mucous layer, and notably in the lacuna. The process is a parakeratosis, but not in the narrow sense which implies a keratinization without intervention of eleidin. In the derma there are connective-tissue cells, mast-cells, and leucocytes. The papillæ are elongated, giving a “vegetating” appearance. The *corps ronds* are held to be characteristic of this disease, not because not met with in other affections, but by reason of their forming the foundation of the lesion. The granules of the keratoid masses are round or polyhedral corpuscles with nuclei. The *corps ronds* are seen below these in the lacunæ, or, better, in the lateral parts of these foci of disintegration. The primary process seems to consist in a granular disintegration of certain mucous layer-cells. In others, there is formed in their protoplasm a ring of refractive substance, which envelops the nucleus, separated from it by a semiliquid, and surrounded by a zone of the same material. Thus the *corps ronds* may appear to be intracellular. Reagents, which color eleidin, show that it may be present or entirely absent. It may be seen around a cell-nucleus which is being transformed into a granule; the *corps ronds* contain eleidin in granulations, in the refractive zone, in the clear contents, or at the nuclear surface.

These facts are scarcely in favor of the theory that the granules and *corps ronds* are coccidia. They are altered mucous cells, resulting from a keratinization abnormal in its mechanism, topography, and even in its ultimate product, which is not eleidin. Darier is not far from the opinion of Boeck, Petersen, and others—an opinion resting solely on microscopic examination. There are certain forms difficult to explain on the hypothesis of an anomaly of keratinization of the cells. The cause, the pathogenic agent of the anomaly, remains to be found.

Therapeutic Notes.

Tuberculin in Lupus.—CAMPANA (Trans., Third Internat. Cong. of Derm. and Syph.) thinks tuberculin brings about resolution of inflammatory infiltrations, but does not prevent relapse. According to Caruccio and Brocchieri, it is a chemical irritant. The acute dermatitis caused by it resembles that of chrysarobin, and its action is the same. It does not influence the bacilli, which are reproduced abundantly in tissues charged with the toxins of tuberculosis.

Hyperidrosis.—FRANK recommends as a dressing, tannoform, a powder composed of formalin and tannic acid. It has given him good results.

Urticaria.—The *Province médicale* is responsible for the following formula, used to relieve the itching of the disease:

| | | |
|---|---------------------|-----------|
| R | Aqua distill., | 450 parts |
| | Aq. laurocerasi, | 50 |
| | Chloral, | 5 |
| | Cocain hydrochlor., | 3 |

An objection to it is its cost.

Arsenic in Lupus Erythematosus (*Deut. Med. Zeitung*, October 5, 1896).—Dr. Schütz of Frankfort, at the Congress of German Naturalists and Physicians held in September, called attention to the poor results of treatment at present, particularly of the long-continued use of strong applications. He has used externally Fowler's solution, diluted with four to six times its bulk of water, and painted on the area affected twice a day. The application, after a time, causes slight swelling and pain. After recovery, it is found that the arsenic has spared the healthy tissue. The claim that there is no scar-formation can hardly be supported.

Ichthyol in Gonorrhea (*Thèse de Paris*, 1895).—Canova claims that a one or two-per-cent. injection is painless and rapidly efficacious. He says he has cured the disease in a period of six days (?).

Balsam of Peru in Scabies.—JULLIEN has his patients rubbed over the whole body, except the head, at night with thirty to fifty grams of the balsam for half an hour. The itching is relieved, and one application usually suffices for a cure.



HYPERTROPHIC LICHEN PLANUS.
(ILLUSTRATING DR. FORDYCE'S ARTICLE)

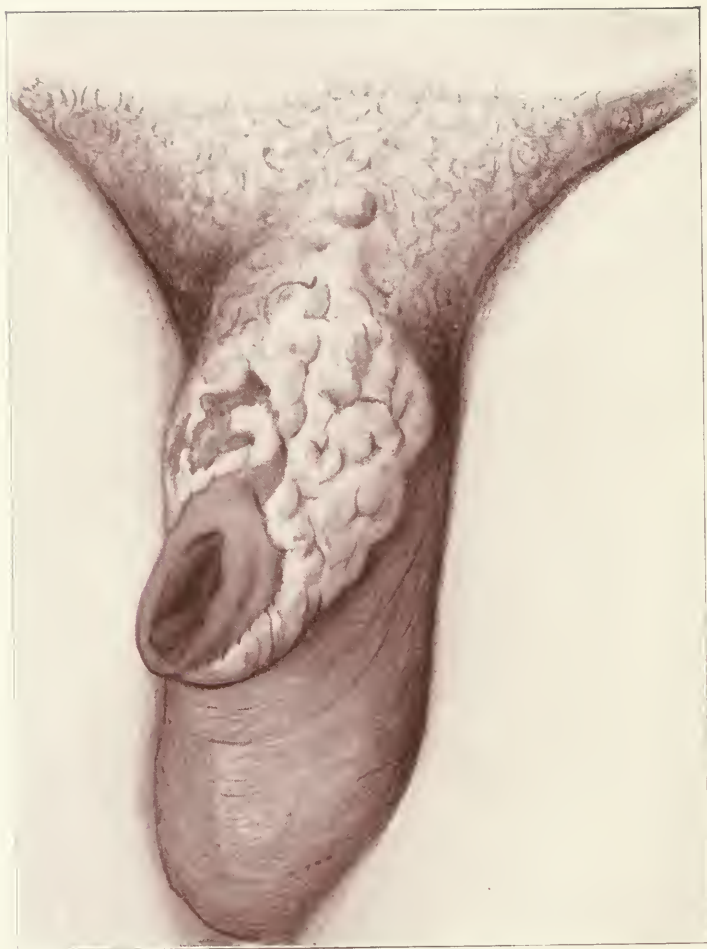


FIG. 2.

HYPERTROPHIC LICHEN PLANUS. (ILLUSTRATING DR. FORDYCE'S ARTICLE.)



FIG. 3.



FIG. 4.—Section through a papule, showing hypertrophy of the epidermis. Spencer 1 in. Comp. ocular 4, Zeiss. $\times 60$.

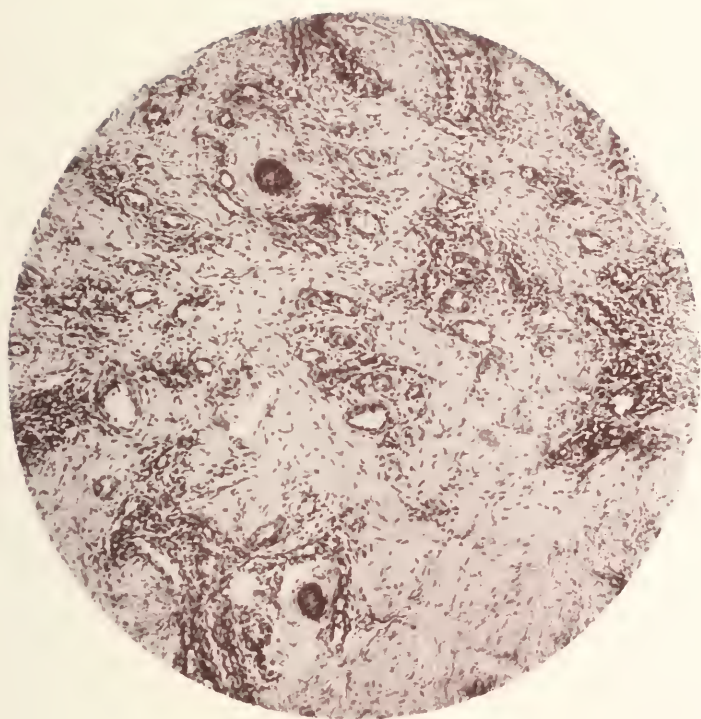


FIG. 5.—Section showing the dilated vessels, cell infiltration, and new formation of connective tissue in the deeper layer of the derma. Spencer $\frac{1}{2}$ in. Projection ocular 2, Zeiss. $\times 100$.

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HYPERTROPHIC LICHEN PLANUS.

By J. A. FORDYCE, M.D.,

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Visiting Dermatologist to the City Hospital, etc.

THE case I am about to describe presents such an unusual and interesting manifestation of a cutaneous eruption as to be worthy of careful study and record.

F. B., aged fifty-four; German; machinist. His father and mother died when they were quite old.

Two children are at present alive from a family of eight.

He gives no history or evidence of venereal disease, and is not of intemperate habits.

He has had on several occasions outbreaks of urticaria on the face and body.

About two and one-half years ago he had an attack of rheumatism of the right knee and ankle, attended with considerable pain and swelling of the parts. He applied for the relief of the pain a number of lotions and liniments, and took "potash" internally.

The skin eruption from which he now suffers began as small itching papules over the anterior surface of the right leg, following the application of the lotions to this part.

Scratching caused a slight watery discharge, but aside from this occasional manifestation of moisture, the eruption has been quite dry and distinctly papular.

The popliteal spaces were next involved, on the right side the lesions being more numerous and larger than on the left. The

penis and scrotum were implicated about eighteen months ago, a small area on the anterior surface of the left leg and a portion of the skin covering the sacrum nine months later.

The upper extremities and trunk have never been involved aside from the localities mentioned. The general health of the patient has, in the main, been good.

The urine contains neither sugar or albumin; the heart is normal.

Description and Sites of the Eruption.—The anterior surface of the right leg is the seat of numerous, closely-aggregated, flat-topped, warty elevations, of a purplish red to a brownish red color, and of irregular outlines. (See Fig. 1.) These lesions are moderately firm, and covered by a thickened stratum corneum, which can be seen as minute horny plugs dipping below the cutaneous surface. Surrounding the warty lesions are a great number of brownish-red papules situated around and independent of the hair follicles. These papules correspond in their main features with lichen-planus papules, having flat, shiny tops, angular outlines, and some showing the central dell. The lesions vary in size from those the size of a pin's head to papules as large as a pea, or even larger, the larger ones assuming the characteristics of the individual lesions making up the warty, elevated areas. Intermingled with and about the smaller papules are individual and grouped sepia-brown to black pigment spots, which evidently represent the involution stage of the papules that have not developed into the larger tumors. This pigmented area extends upward and outward over the leg until it becomes continuous with a similar group of lesions in the right popliteal space. Here the same general condition exists of warty growths, small papules, and pigmented spots, as seen on the anterior surface of the leg. The warty growths in this locality are softer, pinkish to bluish-red in color, and form the most prominent feature of the clinical picture. (See colored plate.) They are elevated from a quarter to half an inch above the skin level, and form a band-like group extending across the popliteal space for a distance of three inches or more. At right angles to this band another group of lesions extends upward. A group of pigmented spots is seen in the colored plate on the posterior aspect of the leg at the site of former papules.

The left popliteal space and the sacral region on either side of the gluteal fold are affected in a similar, though less pronounced, manner.

The genital region is implicated in a most curious and striking manner by the new growths, which are seen as isolated, dome-



FIG. 1.—Hypertrophic Lichen Planus of leg, showing warty growths and pigmented spots.

shaped, hard, purplish-red papules in the hair over the pubes. The skin of the penis, with the exception of a narrow ring about the prepuce, is almost completely surrounded by the papillomata, which have coalesced in a diffuse infiltration made up of elevations and depressions. (Fig. 2, plate.) The growth here is distinctly pinkish in color, quite firm, painless to pressure, perfectly dry, and not marked by evident desquamation. The skin which is not attacked is the seat of a deep patchy pigmentation, and spots of leucoderma.

On elevating the organ its under surface is seen to be the seat of similar warty tumors, which are arranged in the form of bands on either side of the rhaphe, and extend in a continuous, beadlike line of nodules along the rhaphe of the scrotum, suggesting an auto-inoculation from contact with the apposed surface. (Fig. 3, plate.)

The scrotum is deeply pigmented; the inguinal nodes somewhat enlarged, but painless.

The posterior surfaces of the forearms are a trifle pigmented, rough, and show a papular development not unlike that seen in prurigo mitis.

The patient has been under my constant observation during the past six months, during the greater part of the time at the City Hospital, but no marked change has, until recently, taken place in the appearance of the eruption. Arsenic in increasing doses has been given internally, and ichthyol, Unna's salve, and various other local agents employed.

Early in the present year he presented himself with a swollen and painful condition of the left leg, which extended from the dorsum of the foot almost to the knee. The anterior and outer surface of the leg was covered with numerous purpuric patches. The leg was very painful to touch and locomotion was difficult. An abscess subsequently developed near the left ankle which was opened and drained. The infiltrated patch on the right leg was also more swollen and hyperemic, and a number of pustules and abraded spots were found among the old lesions.

Some of the papillomatous lesions had disappeared, while others were smaller and more scaly. Few of the nodules were found in the pubic region, and many of the warty growths had disappeared from the penis; others were softer, desquamating, and evidently in process of rapid involution. The linear growths along the scrotal rhaphe could scarcely be made out.

The condition in the popliteal space, as shown in the colored plate, had undergone little change.

Microscopic Examination.—A papule of medium size was excised,

placed in a five-per-cent. formalin solution for a few days, and afterward hardened in alcohol. The sections were stained in hematoxylin and eosin, and by other methods; the best results being attained by hematoxylin alone, and in combination with eosin. Under a low power the pathological process is seen to involve the epidermis, the derma, and to some extent the underlying connective tissue. The epidermis has undergone marked hypertrophy (Fig. 4, plate), the stratum corneum dipping below the level of the skin in stratified masses, which are visible on macroscopic examination. The stratum granulosum, as would be expected, is several times its normal thickness, the eleidin granules taking the stain intensely.

The stratum spinosum has shared in the general hypertrophic process, extending in the form of interpapillary process deep into the dermal tissues. Detached masses of epithelial tissue are seen away from their epidermic connection, which are actively infiltrated with leucocytes. These separated epithelial groups are in process of rapid disintegration, in some cells the nuclei being absent; and in most of them the protoplasm seems to have undergone a colloid degeneration. This degenerative process involves certain cells in the spinous layer of the epidermis, the nuclei of which take the stain imperfectly or not at all. The epidermis is also the seat of a moderate leucocytic infiltration, more marked between the cells of the deeper layers, but extending in a minor degree to the more superficial region.

The cutis is the seat of pronounced changes of an inflammatory character, consisting of marked cell infiltration, serous exudation, dilatation of the capillaries, small vessels and lymph spaces, connective-tissue hypertrophy in various stages, and newly-formed capillaries.

The cell infiltration is most pronounced in the papillary and sub-papillary layers, made up chiefly of mononuclear leucocytes, with granular protoplasm.

In the deeper layers the connective-tissue hypertrophy is more pronounced, and the cell infiltration limited to the neighborhood of the vessels. (Fig. 5, plate.)

Under a higher power the cell growth about the vessels is, as stated, principally comprised of irregularly shaped cells, with single nuclei, which are undergoing organization into young connective tissue; the caliber of some of the vessels has been destroyed by the growth and contraction of this newly-formed fibrous tissue. In Fig. 5 two such vessels are seen to be almost obliterated by the surround-

ing cell growth. It is probably in this way that spontaneous involution of certain lesions is taking place, as mentioned in the clinical description of the eruption. Sebaceous, sweat glands and hair follicles were absent from the sections examined.

The process is thus seen to be an essentially inflammatory one, of a chronic character, the epidermic hypertrophy differing in degree only from that met with in typical instances of lichen planus. In a recent papule of lichen planus the cell infiltration is sharply limited to the superficial dermal region, but in older lesions of the disease the deeper portions of the cutis are implicated as well.

The microscopic study of the disease, therefore, rather favors the diagnosis of lichen planus, although the clinical picture of certain phases of the eruption is unlike any manifestation of that disease which has heretofore come under my observation. Whether the papillomata bear the same relationship to the underlying inflammation as those met with in certain other long-standing chronic inflammations of the derma, is difficult to determine. In chronic eczema of the leg, elephantiasis, as well as in various other dermatoses, the same sclerotic changes are frequently met with in the cutis, followed occasionally by papillary outgrowths.

It is probable that in all these chronic inflammations the sclerosis of the fibrous tissue, by interfering with the normal nutrition of the epidermis, favors the abnormal growth of this structure. Chronic inflammatory changes in the cutis, by diminishing its normal resisting power, is also at times a factor in determining a downgrowth of the epithelium.

The papillomata, which my patient presented in such a marked degree, could scarcely be looked upon as an accidental or secondary condition, as many of the smaller papules presented in miniature the same appearance as the larger confluent plaques; the warty growths seeming to spring up from the normal skin and not to originate from infiltrated regions, as would probably be the case were they secondary phenomena only. We must either infer that some peculiarity exists on the part of the patient's tissues, which render them more susceptible to the development of such growths, or suppose that some specific organism is present which has the power to stimulate directly the epithelial tissue.

Diagnosis.—The patient whose case has been reported was shown at the October (1896) meeting of the New York Dermatological Society, and while some difference of opinion existed among the members present as to the true character of the eruption, the majority regarded it as an unusual manifestation of lichen planus.

In this opinion Dr. T. Colcott Fox of London, who was present, concurred. The case was afterward seen by Dr. L. A. Duhring, who also believed it to be a rare form of lichen planus. This diagnosis was rendered probable by the numerous small lesions scattered over the lower extremities, which presented all the features of the lichen papule, and which terminated by spontaneous involution, leaving behind pigmented spots and areas.

The lesions on the genital organs, if seen alone, would in no way support such a diagnosis, as none of the usual appearances of the typical eruption were present. It was only by a consideration of the entire eruption, and, by a process of exclusion, that such a diagnosis could be made.

The symmetry of the disease, the intense pruritus, and, more than all, the histological structure of the new growth, were additional arguments in favor of such a diagnosis.

The vegetating growths met with in syphilis, tuberculosis, pemphigus, eczema, elephantiasis, yaws, etc., could readily be excluded by the entire absence of other signs pointing to those affections.

Kaposi's case of lichen ruber moniliformis (*Vierteljahresschrift f. Dermat. u. Syph.*, 1886, p. 571) which has been so often quoted, is considered by this writer to have been a rare form of lichen planus. In some of its features my case resembles this one, notable in the bead-like arrangement of the lesions along the scrotal raphe.

The eruption in Kaposi's case was much more extensive and the moniliform arrangement of the raised nodules more pronounced. In the regularity of their distribution, as shown in the colored plate which accompanies his original article, the raised nodular lines suggest an implication of the lymphatic vessels. The presence of small characteristic papules and brown pigmentations determined the diagnosis in his case as in my own.

Róna and Dubreuilh have observed similar forms since the publication of Kaposi's report. (Referred to in Kaposi's *Pathologie und Therapie der Hautkrankheiten*, vierte auflage.)

The case of lichen ruber moniliformis which is reported by Fox in Morrow's system was one of pityriasis rubra pilaris.

Unna (*Die Histopathologie der Hautkrankheiten*, p. 321) criticises the histological report of Kaposi's case, saying that in no respect do the findings agree with what we encounter in lichen planus. The cell infiltration in the report in question was found in the subpapillary layer of the cutis, and showed no evidence of undergoing connective-tissue transformation. Numerous giant cells were also seen which are not found in lichen planus.

The epidermis, furthermore, showed no marked evidence of hypertrophy; in this respect, as well as in the other morbid changes, differing widely from the affection which I report.

Another case which presents many points of analogy with mine has recently been observed by Corlett (*JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES*, August, 1896) under the title of "A Peculiar Disease of the Skin, Accompanied by Extensive Warty Growths and Intense Itching."

The eruption was made up of reddish, slightly scaling papules on the outer surfaces of the legs. Elevated, scaling patches with warty surfaces were formed by the confluence of individual lesions. The disease subsequently appeared on other parts of the body. After a year's duration it disappeared, leaving pigmented areas, which were slowly absorbed.

Dr. Corlett's case presents many features in common with my own, and I am inclined, after a careful reading of his clinical report, to consider it one of lichen planus.

Note.—An examination of my patient, made after the foregoing report was written, showed that all the lesions were in process of active involution. The warty growths in the popliteal space were softer, smaller, and the pigmented areas were scarcely to be seen. The lesions on the genital organs and leg were decidedly less pronounced than at the last examination.

66 Park avenue.

THE DETECTION OF STONE IN THE BLADDER.

By WILLIAM K. OTIS, M.D.,

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THE detection of stone in the urinary bladder is ordinarily a simple matter, presenting no extraordinary difficulties to the surgeon of average ability; but occasionally cases do occur in which the most skilful and experienced operators find themselves unable to establish a diagnosis in spite of every means at command. Stones, even of large size, have escaped the most careful and minute examination by some of the most celebrated surgeons both of this country and of Europe. In actual practice the presence of stone is so frequently overlooked, especially when it complicates some other pathological condition of the bladder, that no apology is necessary for bringing the subject before you this evening, in order that a thorough discussion may indicate as clearly as possible the

various methods we have at our disposal for the detection of stone, and the relative utility of each.

The rational symptoms presented by patients with stone in the bladder are exceedingly variable in degree; they may all exist together, or one or more only may be present, or, even when the stone is of large size, there may be an entire absence of symptoms; or, any or all of these symptoms may occur without the presence of stone.

Pain.—The symptom which is most commonly present, which is usually the first to attract the attention of the patient, and which is, on the whole, the most indicative of the presence of stone, is pain. This pain may vary from a slight intermittent irritation or feeling of uneasiness or weight in the perineum to a continuous pain of the most excruciating character. These differences being due to the character of the stone, whether rough or smooth, the size of the stone, the length of time it has existed in the bladder, the amount and character of the cystitis present, the mobility of the stone, and to individual idiosyncrasy on the part of the patient. As a rule the pain is moderate in degree, and is severe only at the end of micturition, when the irritated bladder walls are squeezed against the stone by muscular contraction. It is increased by any violent exercise, as riding, dancing, driving, etc., and frequently entirely absent when the patient assumes a horizontal position. A diagnostic point is that the pain usually radiates to the glans penis, frequently, particularly among children, causing the patient to be continually pulling upon the prepuce. I consider this symptom of so much importance that I invariably search every patient for stone who complains of pain or irritation in the glans penis, without any local lesion. Frequently the pain is reflected to the testicles, rectum, or thighs, or even to more distant parts of the body, as the knee, foot, or arm, or the irritation may cause spasmodic closure of the sphincter ani, or annoying priapism, with or without sexual desire, may be present, especially in boys.

Disturbances of Micturition.—Frequency of micturition is very generally present, which is usually more annoying during the day than at night, when, the patient being in a recumbent position, the stone rolls away from the sensitive neck of the bladder and remains quiet, while with enlargement of the prostate and other conditions causing frequency, it is increased at night. Occasionally the stone is fixed in the neck of the bladder, causing a continual dribbling of urine, and at times a complete retention. When the stone is free the patients often have the sensation of something moving in the bladder when they change position, especially when turning in bed,

and the stream of urine may stop suddenly during micturition, caused by the stone stopping up the internal urethral orifice, and necessitating a change of position to dislodge it before urination can be resumed.

Cystitis.—Cystitis is sooner or later almost invariably present to a greater or less degree, but with uric and oxalate stones, no matter how large they may become, ammoniacal fermentation does not occur unless the urine has become infected from without by the introduction of infected instruments. Phosphatic stones, on the contrary, are the product of urine in a state of ammoniacal fermentation and secondary to that condition.

Examination of the Urine.—An examination of the urine in cases suffering from stone may demonstrate a larger amount of albumin present than would be accounted for by the amount of pus, although there may be no other indication of disease of the kidney, and this albumin will disappear after the removal of the stone. This is so-called sympathetic albuminuria, a condition which is also observed in neoplasms of the prostate and trigonum vesicæ.

Hemorrhage.—Hemorrhage caused by the traumatic action of the stone on the bladder walls is a most frequent symptom, and, according to Ultzmann, always exists, though blood may not be present in sufficient amount to be visible to the naked eye. The bleeding usually occurs at the end of urination, and is more profuse after violent exercise. In cases of old patients with congestion of the prostate or hemophilia bleeding may become a very serious complication.

The Microscope.—The microscope as an aid to diagnosis will demonstrate the presence of crystals of lime oxalate, uric acid, or triple-phosphate, indicating the nature of the stone, and the existence of pus and blood-cells, which may not be present in sufficient quantity to be recognized with the naked eye.

History of Patient.—The history of the patient may give a clue as to the probability of the presence of stone. Previous attacks of renal cholic, in which one or more calculi were unaccounted for, pieces of catheter or bougies broken off in the bladder, the introduction of foreign bodies through the urethra, or through wounds of the bladder, or necrosis of neighboring bones, pieces of which may have ulcerated into the bladder and formed the nucleus for a stone.

Physical Signs.—As all these rational symptoms may exist without the presence of stone, while they are exceedingly valuable, other methods are necessary to establish a positive diagnosis.

The Sound.—The most important of these, giving definite in-

formation and easiest of application, is the use of the metallic sound or searcher. This instrument in general should be of small caliber, 15-20 F., have a short curve, in order that it may be readily rotated in the bladder, easily turned down behind a projecting prostate gland, and of sufficient weight to give it firmness in the hand. The presence of stone is definitely determined either by the sense of touch or an audible click given when the point of the instrument strikes the stone. Oxalates and urates give a loud, clear note, while phosphates and cystineous stones only a feeble friction sound. There are many designs in the form of the searcher, differing from each other in more or less important particulars. The form most commonly used is one originated in 1860 by Sir Henry Thompson. This instrument consists of a silver catheter of 15 F., with a shaft 10 inches in length, having very thick walls to give the desirable weight, the eye being on the convex surface at its juncture with the staff. The curve is short, and the distal end slightly bulbous in

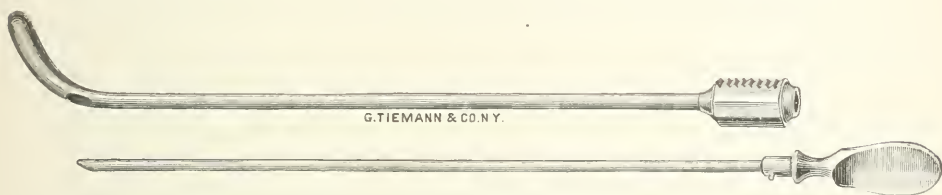


FIG. 6.—Otis' New Canulated Stone Searcher.

form. The proximal end, or handle, consists of a roughened cylinder, one-half inch in diameter and two inches in length, to facilitate rotation of the instrument. A scale with a slide is marked at this end of the instrument, to enable the operator to measure the size of stone. At the extreme end is placed a stop-cock, or plug, to control the flow of fluid from the bladder. In 1891, despite the popularity of this instrument, Sir Henry became dissatisfied with it, especially with its ability to detect very small stones, the importance of which is so great to the patient, as they can then be removed with comparatively little risk, while if allowed to remain they are sure to increase in size, with a corresponding increase in the danger of removal. He says: "There are two chief considerations to be borne in mind in designing such an instrument. First, it should be so formed that all the necessary movements can be made with facility; that (a) the operator may pass it easily into the bladder and also know with certainty the direction of the beak when lost to view; and (b) that he should be able to rotate it with ease between the finger and thumb, when the beak is turned downward behind the neck of

the bladder, especially when, from enlargement of the prostate, the well known depression exists there in which calculus is likely to lodge. The first condition is attained by using the flattened handle of a good old pattern; the second, by placing close to it a small cylinder, a combination which now appears better than the entirely cylindrical handle which he originally introduced for lithotrites and sounds for the purpose named. The shaft of the sound should be rather slender, and the upper surface of the flat handle rough, while the lower is polished, so that the direction of the beak (upward or downward) is recognized by touch.

“Secondly, there should be special adaptation in the form of the beak to strike a very small concretion, and elicit a note therefrom. This is accomplished by flattening the beak a little in the opposite plane to that of the flat handle. It must be manifest to all on consideration, that long as we have been contented to employ a beak of cylindrical contour, this form is especially adapted to avoid direct impact on encountering a small calculus, since these bodies have mostly a nearly spheroidal or ovoid form, and naturally glance off when contact occurs. In fact, a blade flattened in the direction above described is more certain than a cylindrical one to make direct contact, and will transmit to the operator a greater sense of resistance and a more audible note. The wider measurement at the beak which he employs for ordinary purposes may be from 20–22 F., the narrower about 14–15, becoming a little thicker, though still flattened, toward the extremity. Such an instrument passes easily into any fairly healthy urethra, and, in the presence of most forms of enlarged prostate, with rather increased facility in comparison with the ordinary form. It should never be forgotten in connection with seeking a small calculus that the dense fluid medium in which our instrument acts greatly increases the difficulty, as compared with the same action occurring in air—of obtaining rapid and direct contact with a small body of which the specific gravity is comparatively light. Hence the need of flatness and breadth of surface to ensure a direct blow, and the means of moving rapidly to ensure an audible note. It will be seen, however, that in this form of instrument the originator, in order to obtain solidity and distinctness of note, has abandoned one of the principal features which made his original searcher valuable, the ability to control the amount of fluid in the bladder, the instrument remaining *in situ*. In order to reestablish this advantage I have designed a searcher, constructed for me by Messrs. Tiemann & Co., which exhibits all the points of Thompson’s latest model, in fact, is identical with it, except that the shaft is

hollow, the lumen, however, being completely filled by a closely-fitting, polished rod connected with the flat portion of the handle, and held firmly in place by a bayonet catch. By this means all the firmness and weight of the solid instrument are retained, while if it becomes desirable at any time during the examination to vary the amount of fluid in the bladder this may readily be done by removing the rod, and allowing it to escape, or injecting a larger quantity.

Various attempts have also been made to render an increase in the volume of sound produced by striking the stone. The simplest of these consists of a thin wooden disk, five or six inches in diameter, which may be clamped to the handle of a sound, and acts as a sounding board, or resonator. While this instrument is of advantage in demonstrating the presence of stone to a class, it renders the sound so awkward in handling that it is of no practical service to the operator, but the contrary. This is also true in regard to searchers attached to stethoscopes, of which there are several varieties, the best of which is one which I have designed, whereby the sound is connected to the new phonendoscope, but all of which may be considered as ingenious rather than practical. A danger in instruments of this character is that they may be too sensitive, and give indication of the presence of stone when none exists. This was eminently the case with the electro-microphone sound, an instrument devised by the English instrument maker, Coxeter, in 1878, the application of which was followed by disastrous results in several cases.

Position.—In sounding for stone the patient should first be examined in the horizontal position, then standing, and if no stone is detected the Trendelenberg position should be tried. It is sometimes advantageous to examine the patient lying first on one side, then on the other, and to shake him rather violently so as to dislodge the stone from a possible pouch, or to have him assume the knee-elbow position. The amount of fluid in the bladder should ordinarily be about four ounces, though in case of failure the bladder should be examined both empty and distended. If the patient is sensitive the empty bladder should be injected with four ounces of a one-half to one per cent. cocain solution, and this allowed to remain. At the same time a syringe full of four per cent. solution should be introduced into the deep urethra by means of the Ultzmann's syringe. As soon as local anesthesia is complete the sound may be introduced into the apex of the bladder, and the point of the beak turned downward and slowly withdrawn, rotating the beak from side to side by means of the cylindrical handle between the thumb and index finger. If no stone is discovered in the apex or body of the bladder the

region in the immediate vicinity of the prostate should be closely examined. If the prostate is hypertrophied there exists behind it a cavity in which the stone is usually found. The instrument should be withdrawn until it touches the symphysis, the beak turned slowly downward, and the retro-prostatic cavity carefully explored. A favorite seat for calculus is a cavity of the bladder which lies immediately behind the prostate, toward the cecum. Ultzmann, in the case of old men, found the stone in this pouch in eight out of ten cases, and believed that the occurrence of the pouch was due to the fact that when the rectum is filled with hard, fecal masses the entire bladder is not only shifted easily toward the right, but also lifted and turned around its longitudinal axis. From this a cavity of the fundus results, situated near the cecum.

By means of the searcher we are enabled to determine, in addition to the presence of stone, the condition of the bladder; whether its walls are trabeculated, or sacculated; whether it is dilated or contracted; if the stone is free (a very important point if litholapaxy is contemplated), and also to closely approximate to the size of the stone. The stone having been touched, the point of the searcher is moved along its surface to its posterior border. The shaft of the instrument is then grasped between the index finger and thumb, close to the meatus, and the point caused to follow the stone back to the anterior border. The distance on the shaft between the ends of the fingers and the meatus indicates the diameter of the stone. Many searchers have a slide and scale marked on the proximal end of the shaft to facilitate taking this measurement.

Searchers have also been devised for more accurately gauging the diameter of a calculus, but the best means is by the use of a small lithotrite. When the stone is grasped by the lithotrite the amount of separation of the jaws can be read at the handle at a glance, accurately giving a diameter of the stone. The chemical composition of the concretion may also be arrived at by this means, for, if having grasped the stone between the jaws of the lithotrite, a turn of the screw is given and then the catch relaxed, the screw will make the same turn backward if the stone consists of the oxalate of lime, but if it is composed of urates the screw will not turn back. The teeth of the lithotrite bury themselves in the calculus, giving the sensation to the operator as if a thin shell over some hard substance had been crushed: while with phosphatic or cystine stones the teeth sink in easily. At the same time a very small quantity, but still enough, of the stone is usually brought away in the teeth of the lithotrite for chemical analysis.

If more than one stone is suspected of being present one should be firmly grasped in the lithotrite, when, if the instrument is moved about and comes in contact with other hard bodies, the presence of more than one calculus is demonstrated. This may also be determined, though with less accuracy, by means of the ordinary searcher. The reasons for failure to detect stone in the bladder with the searcher are failure to introduce the instrument properly, the operator mistaking an enlarged prostatic sinus for the cavity of the bladder; low specific gravity of the stone, so that it flies away from the searcher without giving sufficient impact to be felt or heard; coating of the stone with mucous or blood clot so that the characteristic sound and touch are absent, the condition being mistaken for a ruga of the bladder wall; encysted stone, where only a small portion may present in the bladder; and stones hidden in sacculations or pouches. Mr. Buckstone Browne has particularly pointed out a not uncommon and particularly annoying variety of the latter, which he terms the Post-Prostatic pouch, which consists in the horizontal position of the trigone of the bladder pushed down between the enlarged projecting prostate in front, and a thickened and firm inter-ureteral ridge behind. Where there is much intra-vesical prostatic projection the pouch may literally be roofed over by this prostatic outgrowth. Calculi in this pouch cause much pain, as the trigone of the bladder has a larger nerve supply than any other portion. Lying as this pouch does, in front of and below the orifices of the ureters, it is a perfectly contrived trap for catching and retaining renal calculi upon their entrance into the bladder, and it is readily seen how favorably they are placed there for growth. If the pouch is deep it may be impossible to find the stone by any instrument passed in through the urethra. In sounding such cases it is not enough merely to reverse the beak of the instrument, but a thorough examination should be made with the reversed beak for the slit-like opening between the intra-vesical prostatic growth and the inter-ureteral ridge, which may be the sole means of access to a large prostatic pouch. To make this investigation Browne has designed a sound with a beak like a flat-bladed lithotrite. It is easily reversed when in the bladder, and is slipped with greater facility than the beak of an ordinary round-ended sound under the projecting lobe of the prostate, allowing the space under it to be as fully explored as is possible with any instrument passed in by the natural passage. Help is sometimes afforded in this exploration by introducing a rectal bag into the bowel before sounding, or by an assistant making upward pressure in the rectum. The cystoscope is useless in these cases, as

is distending the bladder with fluid (which in the case of a post-trigonal pouch is always of service).

While it has been urged that instruments used in searching for stone should have short, abrupt curves, in certain instances the condition of the prostate will not allow an instrument with such a curve to pass; in which case an instrument with a longer curve must be used, and as careful search as possible made. In some instances I have been able to detect the presence of stone with the jointed metal prostatic catheter when other more suitable instruments failed to pass.

The operation of sounding for stone is not always unaccompanied with danger, especially in old men, and every antiseptic precaution should be taken and the greatest gentleness used to render the risk as small as possible.

An exceedingly useful proceeding for the detection of stone is bi-manual palpation with one finger in the rectum, or vagina, and the opposite handmaking pressure over the symphysis. Large concretions can always be felt in this manner, unless considerable hypertrophy of the prostate is present, and in boys even small stones may be recognized.

When the stone is very small, particularly when a fragment is left in the bladder after litholapaxy, they may often be discovered when other means fail by the introduction of a lithotrity tube with the evacuator attached. By making quick pressure on the bulb, causing the fluid in the bladder to swirl, and then suddenly relaxing the bulb the fragment will be drawn into the eye of the tube with a distinct click.

The electro-cystoscope may also be of great service, especially in the detection of encysted stones and small fragments, and it also gives us very accurate information in regard to the condition of the bladder, and the size and character of the stone. In cases where instruments cannot be passed into the bladder Mr. Hurry Fenwick has designed a cystoscope of very small caliber, which is perfectly straight, having no beak. Having punctured the bladder above the pubes with a large trochar and canular, the trochar is removed and the straight cystoscope introduced into the bladder through the canula, and a view of the interior thus obtained. I must confess, however, that personally I should prefer a supra-pubic incision in these cases.

In the female the urethra may be dilated so as to admit the index finger, and a digital examination made without causing permanent injury.

It is occasionally necessary in the male to make an exploratory

operation in order to clear up a diagnosis when other means have failed, and to this end the perineal incision or boutonniere is the one which has been most generally chosen. To my mind, however, the advantages gained by the suprapubic incision far outweigh the slightly additional risk. Examination through a perineal incision, if the patient is stout or the bladder dilated, is exceedingly difficult, whereas, with the supra-pubic incision you have the additional advantage of being able to see and feel the entire vesical interior, at the same time having the best opening through which to deal with any pathological condition you may find present.

The Roentgen ray has been utilized to detect stone, and occasionally might be found useful. I show you this evening a very beautiful radiograph taken by Dr. Francis H. Williams of Boston, demonstrating the relative density of the various varieties of stone and of bone. It will be seen that the urates are easily penetrated by the ray, are not as dense as bone, and therefore could not be detected by this means, that the oxalates are much more dense, and might be seen, while the phosphates are almost opaque and would easily be detected. Fortunately, it is this variety of stone which is most likely to be present, when a diagnosis by means of the Roentgen ray becomes desirable.

MYCOSIS FUNGOIDES AND SARCOMATOSIS.

By JOHN T. BOWEN, M.D.,

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DESPITE the numerous careful studies that have been made of affections of this class during recent years, they are still involved in much obscurity, and their pathology is quite unsettled. It has been found that many cases occur that seem closely related to the known types of mycosis fungoides, but yet vary from these types in some essential particulars, and it may often be embarrassing to decide whether such a case is to be classed as mycosis fungoides, or whether it comes nearer to a true sarcomatosis. Hence Kaposi, who has always maintained that mycosis fungoides is nearly related to the sarcomata, insists that there are transitional forms between mycosis fungoides and true sarcoma, and in the last edition of his work proposes the provisional name "sarcoid tumors" for this whole class of affections, until their pathology has been cleared up and individual types have been more sharply separated. Among his sarcoid tumors Kaposi includes the classical forms of mycosis fun-

goides, his lymphoderma pernicioso, and the various forms of true sarcomatosis cutis, including the multiple idiopathic pigmented sarcoma described by him.

By far the most able and exhaustive pathological study that has been made of these affections in recent years is that of Paltauf, whose paper on the "Lymphatic Neoplasms of the Skin" was read before the Vienna Congress in 1892. The work is of special value as coming from a skilled general pathologist, than whom no one is more competent to form an intelligent opinion on this subject.

Paltauf reviews the various theories that have been proposed with regard to the etiology of mycosis fungoides, and shows that all are open to grave objections. Histologically the tissue is not like that of the infectious granulomata, and no microorganisms of enduring claim to the title of specific agents have been discovered. The theory of the French that it is a cutaneous lymphoma is disproved by the fact that the round cells that constitute the tumor can be shown in some instances to be derived from the fixed connective-tissue elements, although in certain cases there must be admitted to be a close relationship with leucemia and pseudo-leucemia. Kaposi's theory that mycosis fungoides is a form of sarcoma, is rejected on the ground that we must cling to the old dictum of Cohnheim that true new formations never disappear spontaneously, as do the tumors of mycosis in a most striking manner. Furthermore, the appearance of the tumors as symptoms in the course of a disease, and the fact that their growth is not centrifugal, are facts opposed to the conception of sarcoma. Paltauf is inclined to include mycosis fungoides in the class of anomalies of vegetation proposed by Kundrat, which comprises pseudo-leucemia and certain forms of lympho-sarcoma. In this sense it is an affection which owes its origin not to a special cause, but to an abnormal reaction of the individual, and depends upon an abnormal vegetation.

However fanciful and vague this theory of Paltauf's may appear to some, it cannot be denied that he has very ably and cogently set forth the reasons against the various theories that had been previously advanced. For a considerable time it seemed highly probable that mycosis fungoides would be finally placed among the infectious granulomata, and several times the demonstration of a specific microbe seemed imminent. The affection is not a common one, and the cases vary so widely that a report of any that diverge from the classical type is of importance. In two cases that happened to come under my notice at the same time, there are many points of similarity with multiple sarcomatosis of the pure type.

CASE I.—This patient entered the Massachusetts General Hospital in January, 1890. William G., fifty-two years of age, born in Scotland. Engineer. According to the patient's testimony there was no family history worthy of comment. He had always been a strong, healthy man, and had never had syphilis or other venereal disease. Eight months previously, as he thinks after a strain in lifting, both testicles swelled to twice their normal size, and became hard but not painful. A few weeks after this the cutaneous lesions began to assert themselves, and these consisted of small, soft, red bunches, varying in size from a filbert to a large egg, situated on the thighs, calves, abdomen, chest, arms, and face. During the last eight months he has had a great loss of strength and appetite, and his weight has decreased fifty pounds.

Upon inspection he presented the appearance of considerable cachexia. Scattered over the body were nodules varying in size from a large bean to an egg, firm, rounded, moderately raised above the surface, of a deep bluish-red color. They were movable with the skin and did not seem to extend deeply into the subcutaneous tissues. Some of them showed a central depression. The largest lesion was on the left side of the upper lip, and the patient said it had existed for three weeks. Some of the tumors were ulcerated slightly, but there were none of the fungous papillomatous appearances seen in the later stages of mycosis fungoides.

Besides these distinctly defined nodules, there were numerous more superficial lesions scattered over the skin, which the patient said had coexisted with the nodules from the outset. These consisted of slightly elevated erythematous and urticarial lesions, pretty sharply bounded from the normal skin, of a reddish-blue color. These areas had often assumed a distinctly annular form from the involution of the center, so that islands of sound tissue had appeared within their boundaries. These erythematous and urticarial lesions were scattered generally over the body, among the nodules and tumors that have been described above. There are also various patches of pigmented skin scattered over the body, which the patient, a most intelligent man, states are the sites of tumors that have existed and subsequently disappeared.

Both testicles were enlarged to twice their normal size, and were hard, smooth, but not painful on pressure. The lymphatic glands were not enlarged.

The patient was immediately treated with subcutaneous injections of liquor potass. arsenitis, three drops daily, in different parts of the body. Under this treatment a number of the nodules, and especially

one on the left side of the chin, diminished rapidly in size. A few weeks later, however, he began to complain of severe headache and nausea. There was great prostration, with no physical signs to account for it. There was some pain in the left chest. The temperature was at first normal, but later became high. Finally, great dyspnea and delirium preceded his death.

Autopsy.—Twenty-eight hours *post mortem*. Head not opened. Numerous rounded and flattened elevated tumors in the skin of the trunk and extremities, also one of the lip. Also patches of pale brown discoloration, somewhat indurated. A section through one of these cutaneous nodules showed a homogeneous, reddish-gray new formation of the skin, which proved on microscopical examination to be composed of small, irregularly rounded cells, with a delicate fibrous intercellular substance.

Scrotum. Enlarged to the size of two fists in consequence of a new formation in each testis, resembling that seen in the skin. On the right side the tunica vaginalis was normal, on the left the cavity was obliterated. The epididymis on the right side was the seat of the new formation, being enlarged to the size of the end of the finger. The left epididymis not increased in size. The new formation extended along each cord to the brim of the pelvis, as elongated ovoid nodules.

Heart and lungs normal.

Spleen increased in size perhaps one-half, firm, dark red. Trabeculae distinct. Enlargement due to an increase in pulp.

Kidney large. On section pale and moist, with the tubular region distinct. In one kidney a nodule of new formation as large as a pea.

Liver and bladder normal.

Stomach and intestines normal except the vermiform appendix, which was obliterated. In the meso-colon, a short distance above the cecum, was a flattened nodule of new formation as large as a raisin.

Histologically, bits excised from the nodules during life, and material obtained at the autopsy, revealed the same appearances. The lesions consisted of very numerous small round cells, lying within the meshes of a very delicate stroma, which they had apparently pushed aside. There were occasional small irregular and slightly fusiform cells interspersed, but the round cells predominated. A few vessels could be seen with the cell-growth often thicker along their course. The position of the cell-growth was in the lower layers of the corium, extending upward to the papillary layer. There was, however, in

most places, a very narrow layer of sound tissue immediately below the papillæ, and where the cell-growth had not penetrated. The papillæ were everywhere compressed or obliterated. The epidermis was somewhat thinned but otherwise normal. The lesions of the internal organs and of the testicles proved to be of a similar histological character. A careful search was made for microörganisms by the various methods of staining, but none could be found.

In what class is this case to be put? Histologically the lesions were exactly similar to those of mycosis fungoides, with the exception that the papillary layer of the corium was not involved, and that the appearances were less superficial. But the character of the cells and stroma was typical of mycosis fungoides, and presented the variations from true sarcomatosis that have been pointed out by Paltauf and others. The affection of the testicles and the nodules of new formation in the kidney and meso-colon are phenomena that are rare in cases of mycosis fungoides of the pure type, but still they occur.

Clinically the resemblance to true sarcomatosis is quite prominent. The patient's declaration that the testicles had begun to increase in size a little before any cutaneous appearances had asserted themselves, the absence of the pre-mycotic stage of eczema, and the failure of the tumors to ulcerate and become converted into papillomatous and fungous forms, are facts that point toward true sarcomatosis rather than mycosis fungoides. The short duration of the disease may also be included here. On the other hand, we have to note the disappearance of many of the tumors in the way so characteristic of mycosis fungoides, leaving pigmented areas only to mark their site. Furthermore, the urticarial and erythematous appearances were precisely similar to those described by Bazin in the période lichén oïde of mycosis fungoides.

CASE II.—At just about the same time (January, 1890) a French Canadian, forty-eight years of age, was admitted to the hospital with a somewhat similar affection, so that the two cases were present at the same time and could be compared. This patient spoke nothing but a French patois which it was very difficult to understand. It was learned that he had never had any venereal disease, that he had been married at the age of twenty, and had four strong and healthy children. Up to eight months ago he had had good general health. At this time he became aware of a swelling of the right nostril, and soon after a broadening of the bridge of the nose, and much redness of this part. There is now a dark red tumefaction of the right ala of the nose, which nearly occludes the nostril. Seven months ago the left nostril began to swell. It is now ovoid in shape, equal in size to the

two fists clenched, and not translucent. The next event was six months ago, when a tumor appeared on the R. external malleolus. This tumor is now the size of a hen's egg, elastic, not tender, of a light red color. Five weeks ago he first noticed an eruption, which began on the lower limbs and gradually extended upward. Now both legs from groins to ankles are covered with nodules varying in size from a chestnut to an English walnut. Some of them have a decidedly urticarial appearance; others are of a deep reddish-blue color and suggest vividly, at first glance, erythema nodosum. There is, however, much more infiltration than in the latter affection. The same appearances are seen on the trunk, but not in such numbers. In a few places involution had taken place in the center of the plaques, leaving islands of sound skin surrounded by a ring of infiltration, just as in the first case. There are no lesions upon the head, with the exception of a small growth on the conjunctiva of one eye. The patient complains of no pain from the tumors, but he has lost much flesh and is very weak. According to his account none of the lesions have totally disappeared, although many have lessened in size.

The patient was treated for about two weeks with subcutaneous injections of arsenic in the form of Fowler's Solution, four minims daily, subsequently increased to six minims. At the end of two weeks he left the hospital somewhat improved. There was a slight diminution in the size of the left testicle, and the obstruction in the right nostril was lessened. The nodules upon the body were slightly less prominent.

Ten days later I saw the patient at his house. He was much weaker. Since the injections of arsenic had been omitted the testicle had increased rapidly in size. The appearances upon the skin were much the same, if anything more pronounced. It was learned that the patient rapidly failed, and died two weeks later without the appearance of any fresh symptoms.

Unfortunately the record of this case is insufficient, as no autopsy was made, and the histological examination is not recorded. It was found, however, to correspond pretty accurately with Case I. The short duration of the disease before the fatal termination—about nine months in one case and eleven months in the other—the implication of the testicles in both cases in the early stages of the disease; the very slight amount of ulceration or breaking down of the tumors; and the presence, in addition to the tumors, of urticarial and erythematous lesions exactly like those that are often seen in mycosis fungoides of the pure type—these are points of similarity that may be especially accentuated.

In one feature, and that an important one, the two cases differ, and that is that so far as could be learned there was no spontaneous involution of any of the tumors in Case II, although there was a considerable improvement under arsenic. For this reason, and because a careful histological examination of the growths is lacking, it may be properly maintained that Case II approaches the type of pure sarcomatosis much more closely than Case I.

Spiegler, in a recent article, relates cases where the histological appearances were precisely those of sarcoma, yet the growths exhibited, contrary to our conception of malignant neoplasms, a circumscribed non-progressive character, and a capacity for complete involution. Hence he would separate these growths from the true sarcomata, as Virchow himself had admitted that the clinical course must be taken into account in the classification of neoplasms.

Are we to keep strictly to the classical conception of sarcoma, as a neoplasm that is incapable of spontaneous involution? If we accept this position Case I cannot be regarded as a sarcoma, and furthermore, the histological character varied from that of sarcoma to some extent. But if we exclude on this ground mycosis fungoides, and instances like Case I, we must also exclude the multiple idiopathic pigmented sarcoma of Kaposi, one of the attributes of which is spontaneous involution, but which has been accepted as a distinct species of sarcoma, on account of the typical character of its tissue histologically.

It seems to me wisest at the present time to admit that our knowledge of these various affections is in a most confused state, and to keep our minds open to all evidence that may be derived from future studies. It will not do to class mycosis fungoides definitely as an infectious granuloma, as its claim to be placed in that category has not been proved. Many good reasons can be adduced against the theory that it is of a sarcomatous nature; and yet the fact, as I have endeavored to emphasize, that there are cases where it may be difficult to say whether we have to do with mycosis fungoides or sarcomatosis, compel us to admit that a relationship with the sarcomata must still be regarded as a possibility.

With regard to leucemia and pseudo-leucemia, instances of the association of cutaneous tumors with these affections have for a long time been known. It is not my purpose to discuss this subject thoroughly, but to refer briefly in conclusion to two typical cases of pseudo-leucemia, in which nodules, similar to the typical prurigo nodule of Hebra, were found.

Wagner¹ was the first to report three cases of pseudo-leucemia in which nodules were found in the skin resembling those of prurigo, and later Josef² has written upon the same subject with the report of a case. The nodules were regarded by Josef as of a leucemic nature, and not as had been assumed by Wagner as of the same nature as true prurigo. This opinion was strengthened by the fact that in the cases of pseudo-leucemia the nodules were found on the head, as well as on the body. Histological details are wanting or meager in both cases.

The two cases that were seen by me at the Massachusetts General Hospital represented typical examples of pseudo-leucemia. In both the glands about the neck were greatly enlarged, in one there was an enormous hypertrophy of these structures. In the first case, a woman of thirty-eight years, there was a light bronzing of the whole skin, that had existed for nine months, and an excessive general pruritus, that was betrayed by numerous excoriations and scratch marks, with considerable eczematous thickening. On the extensor surface of the legs and feet were small, firm nodules resembling, to a marked degree, the true prurigo nodule, the only difference being that they were somewhat larger, as a rule.

In the second case, also a woman, of about middle age, there was much general cachexia, and a very deep pigmentation of the whole skin, much like that seen in Addison's Disease. There was intense pruritus, and many excoriations from scratching, with some thickening of the skin, or lichenification. Nodules exactly like those of true prurigo were situated on the extensor surfaces of the arms and legs. There were also numerous scars, in some places of considerable size, which were probably the results of violent scratching.

In the first of these cases a nodule was excised from the leg, hardened in alcohol, imbedded in celloidine, and cut into sections, which were stained by the various methods. The results of this examination were interesting. The abnormal appearances in the corium were slight, consisting of a very moderate accumulation of round cells about the blood vessels. The epidermis contained a cyst in the upper portions of the rete Malpighii, the walls of which were formed of cornified epithelium. The contents of this cyst had escaped from many of the sections, but in others it was present as a granular detritus mingled with remnants of blood and epidermal cells. Besides the cornification of the walls of the cyst, the horny layer was generally increased in thickness over the lesion. In short, the ap-

¹ *Deutsch. Archiv f. Klin. Med.*, 38 Bd.

² *Deutsch. Med. Wochensc.* 1889, 46.

pearances were almost precisely similar to those described by Leloir and Kromayer as present in the stage of full development of true Prurigo Hebra, and accorded with the illustrations of prurigo in Leloir and Vidal's histological atlas.

These nodules were regarded by Wagner as analogous to those of prurigo, while Josef seeks to show their variance from the latter type, and to place them in the category of cutaneous lesions of leucemic structure. Despite their occurrence upon the head in one or two instances, it seems to me most rational to regard them as akin to the nodules of true prurigo, as their clinical aspect and histological structure agree completely with the latter. We have also present an intense pruritus, and a pigmentation and thickening of the skin. It is not impossible that a study of cases of pseudo-leucemia which present these prurigo nodules may throw some further light on the much discussed question of Prurigo Hebra. That they do not represent a leucemic neoplasm, but are produced in some way analogous to those of true prurigo, probably through the medium of the nerve channels, seems to me evident.

Clinical Notes.

THE PATHFINDER.

By W. F. ROCHELLE, M.D.,
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THIS simple device is intended to facilitate the introduction of a filiform bougie when the stricture is very small and tortuous, and, as the name Pathfinder indicates in a measure its use, I have elected to give it the name. The idea is an outgrowth of a method described by me in the *JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES* for October, 1885, but differs essentially from that method in the points that oil and piston pressure are used in this, while water and water pressure were suggested in the former.

I was sitting in a clinic-room last May, in New York City, and watching a futile attempt at filiform introduction by an expert operator. He suggested the injection of warm olive oil to lubricate the parts and stretch the stricture. It then occurred to me that the oil pressure did even more than dilate; at the same time it tends to straighten the tortuous canal. A step further naturally suggested

itself, and to devise a simple method that would allow the bougie to enter while the pressure was on next engaged my attention.

After formulating the idea, I had Messrs. Geo. Tiemann & Co. make one, and they also kindly furnished the cut below, which shows the instrument at a glance.

C, b, a, respectively, show the oblique nozzle, the filiform in po-



FIG. 7.

sition, and the packing chamber, in which is a perforated rubber disk, or valve, to prevent reflux of the oil. To this is attached a strong three-ounce syringe, made specially for it.

The technic of its use will naturally suggest itself, and consequently needs no further comment.

A RARE CASE OF ACQUIRED GENERAL HYPER-TRICHOSIS.

By VALENTINE ZARUBIN, M.D.,
Charkoff, Russia.

GENERAL development of hair over the body is the most interesting and rarest sort of hypertrichosis. A case of that kind was described by Erasmus Wilson¹ in 1878. This was a woman, unmarried, aged thirty-three years, whose whole body, except a bald spot on the crown of the head became covered with an abundant growth. It began at the time of puberty. The head, face, body, neck, and extremities developed stiff, blackish hairs, 2.5 ctm. long, so bushy that they perfectly concealed the skin. The woman was of strong constitution, but scrofulous, and suffering from amenorrhea.

A similar case has fallen under my observation.

¹ Wilson. Lectures on Dermatology, London, 1878.

Anamnesis.—Maria Nekrassova, aged thirty-eight. Her circumstances were affluent. She married at twenty-three, and bore a child after a year. Two years later a pregnancy was interrupted at the eighth month, the child dying. She was in bed for six weeks, and had much pain in sexual sphere. She first remarked an abundant growth of hair on the breast. A little later, the whole body was covered, and finally, after three months, the face. From this time, her head began to grow bald. Six weeks after child-bed her abdomen began to enlarge enormously, but pregnancy was not recognized by the accoucheurs consulted. For three years, our patient consulted physician after physician, and tried every means to rid herself of beard and mustache (shaving, pulling the hair out, epilation by electrolysis), but without avail. Six months after the abdominal swelling was reduced, but the pain continued. Having exhausted her money, she exhibited herself to the public. The family history shows no such anomaly.

Status Presens.—The woman is tall, strong, and well nourished, a brunette. The whole surface is abundantly covered with hair, especially the face, where it is nut-brown in color. The hair of the beard is soft and fine. The same is true of the body, except that the growth is shorter. The head is so bald that a wig is worn to cover it. The genital and axillary hair is seemingly normal. No peculiarities are to be remarked in the teeth. The breasts are well developed, the carriage is masculine, and voice coarse. Menstruation appeared at sixteen. After the first year the periods were abundant, regular, and lasted seven days. After her premature labor the menses did not appear in eleven years. Sexual appetite is normal.

Gynecological examination shows hypertrophy of the clitoris, with a well developed glans and prepuce. The other organs are normally feminine. There is a left-sided salpingo-oöphoritis.

As to the etiology of the case, one sees that heredity has no place. The anomalies in the sexual sphere, pointed out by various authors, are present in this instance (*amenorrhea*). In the cases of De Creccio,¹ E. Hoffmann,² Durval,³ and others, beard and mustache existed in pseudo-hermaphrodites of feminine sex. In our case, we have a false feminine, external hermaphroditism (*pseudo-hermaphroditismus femininus externus*). The etiological factor is, very possibly, a severe psychical disturbance.

(Lesser [*Correspondenzbl. f. Schweizer Aerzte*, xxvi, p. 355] has re-

¹ De Creccio. *Il Morgagni*. 1865.

² Hoffmann. *Wien. Med. Jahrbucher*, iii, 1877, S. 293.

³ Durval. *Virchow's Jahrbucher*, 1877, S. 81.

ported a similar case of a girl of six in whom the growth began at the age of four. Besides the hair on face, pubes, axillæ, body in general, the child exhibited signs of precocious development, menstruating first when three years of age.—Ed.)

Society Transactions.

THE THIRD INTERNATIONAL CONGRESS OF DERMATOLOGY AND SYPHILOGRAPHY.

(Continued from page 29.)

The Nature and Connections of the Erythema Multiforme Group.

DR. VEIEL (Cannstatt.) Exudative multiforme erythema is an infectious disease, benign, non-contagious, perhaps miasmatic. It is often epidemic, but is never accompanied by grave complications. External irritations play no rôle in its production, and in the cases observed by Kaposi and Lewin, following irritation of the urethra, the condition is not a true erythema multiforme. Erythema nodosum must be separated from multiform erythema. This is a different infectious disease, often accompanied by grave complications, and especially seen in the tuberculous or hereditary cachectics. The multiform exudative erythema of Hebra has no connection with acute articular rheumatism, while erythema nodosum certainly has affinities with it, without being identical. Multiform erythema must be clearly separated from the erythemata which occur in the course of various infectious diseases, such as cholera, diphtheria, typhoid fever, etc. They are all of embolic nature, and due to the action of microbes or their toxins.

DR. STEPHEN MACKENZIE (London). The author has observed that although in the last few years certain important work has been undertaken to arrive at an exact clinical knowledge of this group and its anatomical forms, no light has as yet been thrown on its pathology. Etiology should form the basis of pathology. Clinical varieties and histopathological variations which accompany them are of minor importance in comparison with the knowledge of the causes which produce them. He analyzed 167 cases as a contribution to the etiology. It is important to observe, in the first place, the great predominance of the disease in women. The figures show a proportion of four women to one man, and in the case of erythema nodosum, of five to one. In the second place, as regards age, the greatest proportion is found in the first three decades and especially in the second and third. The sole associated condition or special cause numerically important is rheumatism. It is clearly demonstrated that in the cases of erythema nodosum articular rheumatism exists in

twenty-two per cent., or 26 of the reporter's 115 cases of this type. Adding these 115 cases to 108 already observed, the proportion is 43 in the 233, or nineteen per cent. Valvular disease of the heart was present in 9 cases of this variety. Among other possible causes or associated conditions are gout, tuberculosis, epilepsy, hysteria, melancholy, uterine disease, headache. One of his cases ended in death, due to nephritis. Passing to the other varieties of erythema, acute, articular rheumatism was seen in 11, subacute in 8, showing a proportion of thirty-five per cent. Valvular lesions of the heart were found in 4 cases, of which one ended in death. Two cases died, one of endo-pericarditis, the other of fatty degeneration of the liver. Up to what point is one justified in considering an individual case of erythema multiforme as of rheumatismal nature, when symptoms of arthritis are lacking? The author thinks that the association of the two diseases is frequent enough to admit the identity of their nature. He discussed the pathology of rheumatism. We know nothing definitely but can probably obtain a deeper knowledge of its nature by study of the erythemata. In the majority of cases certain toxins penetrate into the circulation, and this supports the proposition that morbid products of rheumatism are found in the blood. It is possible that there are other causes which act in the same manner as the poison of rheumatism.

Discussion.—DR. JANOWSKI (Prague). It is necessary to separate erythema multiforme, on the one hand, from erythema nodosum, and on the other from grave erythemata consecutive to an infection by pus organisms.

DR. BULKLEY (New York). Erythema multiforme is not easy to confine within any limits. It is often difficult to distinguish it from dermatitis herpetiformis. Erythema multiforme is above all things an acute disease, which, according to personal experience, is due rather to digestive troubles than rheumatism. In American ports we often observe recent immigrants attacked by the disease who have just undergone a long period of defective alimentation and constipation.

DR. DUBREUILH (Bordeaux). Erythema multiforme is the mean type of a long series, which, starting from erythema purely macular, passes by insensible transitions to erythema nodosum. This eruption is the result of an intoxication acting perhaps through the intermediary of the nervous system, and which is due habitually to infectious toxins, sometimes to those of digestive origin, exceptionally to external poisons. Typical erythema multiforme is that in which the eruption constitutes almost the entire disease, but even then one may almost always find some articular pain. It may, however, occur with a number of other infectious diseases, and notably articular rheumatism.

DR. MACKENZIE (London). It is probable that there are geographical differences in the disease. In England, and notably in London, it is generally accompanied by rheumatic manifestations, articular or ab-articular; at New York and Boston digestive troubles seem to play the principal rôle, but he believes that at Chicago relations with

rheumatism are more intimate. In other countries it seems that other factors still may bring about the same results.

Malignant Syphilis.

DR. HASLUND (Copenhagen). Malignant syphilis is simply a form of secondary syphilis with no relation to tertiarism. The name is not commendable, for, on the one hand, it is already employed for different forms of the disease, and on the other we cannot give to a disease the qualification of malignity in the sense used with other diseases. Prognosis is oftenest favorable. In 8691 patients treated in Copenhagen in fourteen years, he has seen 39 cases of malignant syphilis. As regards treatment, it is impossible to give precise rules. Medication must differ according to the case. The general condition of the patient, the gravity of symptoms, and the treatment previously pursued, must be taken into consideration.

DR. NEISSER (Breslau). Under the name of malignant syphilis we understand a special or specific form of syphilis of an evil nature, but not all those forms which endanger life by localization in the essentially vital organs, or by accidental complications with other dycrasia. The name *syphilis gravis* is convenient, and it is correct, but it is correct in the case of the forms last mentioned, not in the first form of syphilis indicated. The form of syphilis described as malignant is relatively rare to-day, and corresponds to the varieties seen at the end of the fifteenth century in the first great epidemic.

Malignant syphilis is characterized by the following symptoms: First, general phenomena indicating intoxication, such as fever, anemia, cachexia; second, eruptions of large pustules and ulcers on the skin and mucous membranes, rarely in the internal organs, which appear in the first months, from the third to the sixth, after infection, often relapsing. The forms of hemorrhagic syphilis do not constitute in themselves malignity, but they may complicate the ulcers and present a symptom. Scurvy is a grave complication of every syphilis, but it is not the cause of a malignity. Notably in women we see cases with a polymorphous eruption, papulo-squamous, nodes with pustular syphilomata and superficial ulcers, which one can regard as forms of transition of the ordinary syphilis to the malignant.

Malignant syphilis is a precocious form not only from the time of its appearance, but also by the multiplicity and dissemination of the eruption, as well as by the general symptoms seen only in precocious forms, never in tertiary syphilis. It is distinguished from the normal precocious forms (macular and papular) by the processes of destruction and ulceration which often cannot be arrested by medication. Since malignant syphilis is an ulcerous form, it is not a gummatous, tertiary variety. The author then goes further into the differential points.

Appreciation of the case is more difficult when the foci are not visible on the surface of the skin or the mucous membranes, but are found in the internal organs. The majority of writers consider these visceral localizations as tertiary forms, even when manifested in a

secondary period, but the author is of the opinion that the two should not be placed on a parallel. In the cases of visceral syphilis in the first years of the disease we employ as a curative remedy mercury, which is indispensable in the precocious period, not the iodid of potassium, the curative remedy of tertiary syphilis. One is often able to prove the hypothesis of a tertiary form if prompt action is obtained by iodid of potassium. Isolated observations appear to confirm the opinion that there is a malignant syphilis of the viscera analogous to the ulcerative processes of the skin, especially if the evolution of cutaneous symptoms of these cases correspond to that of a malignant syphilis. Malignant syphilis may be acquired or hereditary. It is not possible to invoke the hypothesis that the virus is qualitatively more powerful than in cases of normal evolution, for it has been established that the source of infection in both is the same. It is necessary, then, to conclude that the malignant form is due to a special susceptibility of the individual which is specific. Robust and healthy individuals are often attacked by the malignant form, while sickly subjects have only a benign disease. With the development of ulceration of tissue there is naturally produced a mixed infection of pus organism. This is only a complication of the ulcerous process. These ulcerations frequently heal, leaving keloids. The form, the course, and the site of the primary lesion have no influence on the origin of malignant syphilis. If, however, phagedenism is seen in the primary lesion, we are justified in considering the possibility of the appearance of the malignant syphilis. Subjects attacked by this form do not take mercury well. It is necessary to begin treatment with great care. Iodid of potassium often gives good results, but frequently all the specific cures fail and we are reduced to general therapeutic remedies. It has never been shown that material treatment commenced too early or too energetically has anything to do with the course of the disease.

Discussion.—DR. TARNOWSKY (St. Petersburg). The degree of malignity of syphilis is based on the harm caused the organism. Form, symptoms, and localization, have an influence on the gravity of the disease. Pus organisms find in certain subjects a proper soil which they invade, and in which they develop at the same time as the syphilis. The sum of the toxic effect of the mixed pyosyphilitic infection influences the course of the disease, and communicates to it, especially in the primary and secondary periods, great acuteness, as well as a tendency to relapse. The pyosyphilitic nodes may be absorbed under a proper treatment. The faculty of communicating the contagion distinguishes these nodes from the tumors and gummatous ulcers which are not infectious. Outside of pyosyphilitic infection, syphilis itself may become malignant. This form is betrayed by, notably, the character of the lesion at the border of the chancre, which progresses by necrosis. It is betrayed again by a premature passage to the gummatous period. This last is manifested sometimes without the patient undergoing secondary accidents. The reasons for this are still to be discovered. Absence of medication is not sufficient. Localization and consecutive symptoms exercise

equally a great influence on the gravity of the harm which syphilis does the general organism. There are three types of syphilis gravis, pyosyphilitic infection, syphilis with premature gummatous accidents, syphilis with unfavorable localization, the three often combining with each other, or exhibiting intermediate forms. Mercurial treatment systematically carried out for two or three years offers a powerful auxiliary in combating the grave form of the disease. In the center and north of Russia, of all methods of administering mercury, the intramuscular injections are those which bring the promptest and most satisfactory effect. The preparations used are calomel, bichlorid, yellow oxid, and salicylate, the last being preferable because less painful.

DR. SCHWIMMER (Budapest), has obtained good results with subcutaneous injections of spermin. Mercurial treatment is taken up when the general condition has been ameliorated. DR. FEULARD has employed with advantage a dog serum in this form.

(To be continued.)

NEW YORK DERMATOLOGICAL SOCIETY.

TWO HUNDRED AND FIFTY-FIFTH REGULAR MEETING, HELD ON
TUESDAY EVENING, OCTOBER, 19, 1896.

DR. J. A. FORDYCE, *President, in the Chair.*

A Case of Dermographism.—Presented by DR. H. G. KLOTZ.

The patient, a boy nine years of age, had always enjoyed good health except a mild attack of scarlet fever and measles several years ago. He is in perfect health now, no irregularities of the digestion, nor signs of any nervous troubles being present. Last spring the mother accidentally observed that after rubbing him dry after a bath, the skin, particularly on the face and around the neck, would show a decided whitish swelling, which would disappear after a while without any sensation. On examination it was found that the symptoms of dermatographism or autographism were present. A few minutes after being touched or slightly scratched with some blunt pointed instrument, the letters or outlines inscribed appear as white or light pink, narrow ridges, surrounded by a narrow red zone, without the slightest feeling of heat, itching or other sensory disturbance. After a short time the raised portions grow pale, flatten down, and disappear without leaving a trace. During the summer, when the boy was living on the seashore and took daily salt-water baths, the condition had almost disappeared, to become more pronounced again after his return to the city.

The case seems to be of interest,

1. On account of the occurrence in a healthy child free from any disturbance of the alimentary canal, and from hysteria or other nervous conditions usually favoring autographism,

2. Because it seems well adapted to raise the question whether dermo- or autographism is to be identified with urticaria factitia or

to be considered as a separate disease, distinguished by the absence of inflammatory and sensory phenomena, or simply a motor neurosis.

Dr. K. is inclined to side with Brocq and other French authors in favor of the latter opinion.

A Case of Pemphigus.—Presented by Dr. G. H. Fox.

The patient was a boy with an eruption on the face, arms, legs, and about the genitals; there were numerous bullæ, the size of a split pea or larger. The lesions seemed to be undergoing a serpiginous course.

Dr. Fox said we have heard so much about dermatitis herpetiformis during recent years, that pemphigus seems to have gone out of fashion. He had recently seen a number of cases similar to this one.

A Case of Dermatitis Herpetiformis.—Presented by Dr. P. A. Morrow.

The patient was a middle aged man who came under observation about a month ago. The eruption first made its appearance four years ago on the arms and chest, and since then it has disappeared and reappeared several times. It is very itchy. Bullæ first appeared on arms and legs in July, 1896. A variety of eruptive elements, wheals, papules, etc., have been seen from time to time. There is much edema of the legs and feet, and some pigmentation. The urine contains neither albumin nor sugar. He has had no nervous symptoms.

A Case of Dermatitis Herpetiformis.—Presented by Dr. Bulkley.

The patient is a young man of twenty-four, with good physical development. The eruption began five years ago, appearing first in popliteal spaces and bends of the elbows, from which it spread to other parts of arms and legs. Sometimes the blisters would be quite large. Up to nine months ago, the eruption was confined to arms, legs, and buttocks, but since then has developed on chest, abdomen, and back; it has also been on the face and in the scalp. At times bullæ, small in size, have appeared, while at other times erythematous lesions only are manifest. He had received almost continuous treatment, including ice-bags to the spine, but the lesions continued to appear during the treatment. He has been in the Skin and Cancer Hospital the past six weeks, but has improved only slightly under treatment. Two weeks ago he suffered from quite an eruption of vesicles and bullæ. Patient says that he practised masturbation very greatly from a very small child, perhaps for five years up to eighteen or nineteen years of age; he stopped shortly after beginning of the eruption.

Present State.—Groups of papules and vesicles on an erythematous base scattered irregularly and rather profusely over arms, legs, and trunk, patches varying in size from only a group of two to three lesions to areas nearly the size of palms. Face and scalp at present free, no bullæ to be found when first seen. All eruptions much aggravated by the scratching which the intense pruritus has induced.

A Case of Dermatitis Herpetiformis.—Presented by DR. GEORGE T. JACKSON.

The patient was a young man who came under observation several weeks ago. The eruption had first made its appearance about four or five years ago. Under the administration of arsenic it has largely disappeared, leaving only the pigmentation.

It was decided to discuss Dr. Fox's case of pemphigus, and the three cases of dermatitis herpetiformis, presented by Drs. Morrow, Bulkley, and Jackson together.

DR. T. COLCOTT FOX of London, who was present, was invited by the President to take part in the discussion.

DR. ROBINSON expressed the opinion that the case of so-called pemphigus shown by Dr. Fox was one of dermatitis herpetiformis. He thought symptoms of that eruption were apparent now, and would further develop in the future.

DR. SHERWELL asked the privilege of being allowed personally to express his pleasure at the presence of Dr. Colcott Fox, and at the same time to express publicly (which he had often wished to do) the sense of obligation he felt to his elder brother, the late Dr. Tilbury Fox.

DR. BRONSON said he agreed with Dr. Fox that if there is such a thing as pemphigus, it was perfectly legitimate to call his case by that name. Regarding Dr. Morrow's case, he was in doubt whether it was pemphigus or dermatitis herpetiformis.

DR. JACKSON said he thought the case shown by Dr. Fox was undoubtedly one of pemphigus if we allow the existence of such a disease. The itching, which Duhring speaks of in dermatitis herpetiformis, was entirely absent in this case.

DR. G. H. FOX said that, Professor Duhring to the contrary notwithstanding, he could not bring himself to believe that all the cases shown were examples of the same disease. The cases shown by Drs. Bulkley and Jackson he would regard as belonging to that chronic, relapsing, pruriginous disease which Duhring has described as dermatitis herpetiformis, but he could not include in the same category a case like his own, where the bullæ became large and tense, and seem rather more like the lesions of contagious impetigo. In Dr. Morrow's case, he did not care to venture a positive diagnosis; he would not insist on calling it pemphigus, as described by Hebra, but he regarded that case, as well as his own, as entirely distinct from those presented by Drs. Bulkley and Jackson.

DR. T. COLCOTT FOX said Dr. Bulkley's case was typical of what is known in England as dermatitis herpetiformis. Dr. Fox's case would be classed there as pemphigus.

DR. C. W. ALLEN said he regarded Dr. Fox's case as entirely distinct from dermatitis herpetiformis. It was similar to several cases shown in the past—one by himself, which he had presented as the bullous form of impetigo contagiosa universalis.

DR. GEORGE T. ELLIOT said he agreed in part with the statements made by Dr. Fox, but there is absolutely no resemblance between the course and lesions of contagious impetigo and those of pemphigus.

He did not consider it possible to make a diagnosis of pemphigus or dermatitis herpetiformis from seeing a case once; these patients must be carefully observed for some time. The speaker said he had recently had a conversation with Dr. Duhring, who then stated that when he employed the term "herpetiformis," he did not intend to imply that the disease had anything whatever to do with herpes; he simply used it as suggesting a neurotic disease, the same as we regard herpes. He employed the word in a pathological sense.

DR. ROBINSON said that at the meeting of the American Dermatological Association recently held at Hot Springs, Dr. Duhring stated that he used the term herpetiformis entirely from a clinical standpoint, and not from a pathological one.

A Case of Small Spindle-celled Sarcoma or Carcinoma.—Presented by DR. A. R. ROBINSON.

The patient was a girl, twelve years old. About two years ago a small nodule appeared on the scalp. It was diagnosed by a surgeon as a cyst, and operated on. Soon afterward it reappeared, and became surrounded by an area of indurated tissue about $1\frac{1}{2}$ inches in diameter. It was again operated upon and the wound allowed to granulate. Last spring it again appeared, with more extensive induration, and about two months ago the glands in the neck became enlarged. Dr. Robinson said that he had not yet had an opportunity to examine the lesion microscopically; he regarded it as either a small spindle-celled sarcoma or a carcinoma, but most probably the latter.¹

DR. T. COLCOTT FOX inquired whether any of the members had employed hypodermic injections of arsenic in cases of this character, and, if so, with what result? He stated that at the recent meeting of the International Dermatological Congress in London he showed a case of multiple round-celled sarcoma, and Professor Kaposi, who was present, earnestly tried to induce him to give the hypodermic use of arsenic a trial.

DR. MORROW said he had used arsenic hypodermically in a disease somewhat allied to sarcoma, namely, mycosis fungoides. Under the influence of the drug, the tumors disappeared, although he could not say that this was due to its method of administration. There was a much more rapid disappearance of the growths in the immediate neighborhood of the injections than elsewhere. When the treatment was discontinued, the tumors returned, and the patient's general condition was worse than before.

DR. G. H. FOX said he had employed the treatment in one case of mycosis fungoides. That patient died.

DR. ELLIOT said he had tried it in psoriasis and lichen planus. The injections proved so painful, however, that after the third injection the patients declined to submit to the treatment. The pain lasted from twelve to thirty-six hours.

DR. S. LUSTGARTEN said he had had considerable experience with the hypodermic use of arsenic, and he could not agree with the

¹ The case was one of carcinoma, as shown since by microscopical examination.—A. R. R.

statement made by Dr. Elliot regarding the painfulness of the method, if certain precautions are taken. The sodium salt should be employed. This is dissolved in a two-per-cent. solution of carbolic acid, boiled and filtered each time, and then injected deeply under the skin of the back. It scarcely gives rise to any pain. If the injection is made into the skin, it generally causes a circumscribed gangrene. In condyloma fungoides, the treatment gives only temporary improvement. In Kaposi's type of sarcoma, its effect is practically *nil*. In the more benign form of sarcoid growths, it might exert a favorable result. In one case of supposed osteo-sarcoma coming under his observation, originating from the sternum and involving the axillary glands, after a prominent surgeon had declined to interfere, the hypodermic use of liberal doses of arsenic produced a complete cure in three months, in which time about 45 grains of arsenite of sodium had been injected.

DR. PIFFARD inquired what advantage was claimed for injecting the drug subcutaneously? He was opposed to that method of administering drugs when the same effects can be obtained by giving them by the mouth.

DR. LUSTGARTEN said that a more energetic effect is claimed by administering the arsenic subcutaneously.

DR. ELLIOT said that in the cases where he employed the treatment he observed no abscess formation. The injections were made deep into the subcutaneous tissue, Fowler's solution being employed. Both of his patients were physicians, and after a few injections they stated that the pain was so severe that they preferred to keep their disease indefinitely rather than submit to the treatment.

DR. MORROW said that in one case under his care he had made at least ten injections during the past two weeks, administering 5 drops of Fowler's solution in a little sterilized water. The patient had complained of no pain—at least none subsequent to the time of injection; there had been no nodular formations, and the patient preferred this method to the malaise and gastro-intestinal disturbance that followed the internal use of the drug.

DR. ROBINSON said that in one case of cancer coming under his observation the patient had received three injections of 20 drops each of the drug per day for six weeks without any appreciable effect on the disease. In that case the patient did not complain of pain after the injections, nor did they give rise to abscesses.

A Case of Anesthetic Leprosy.—Presented by DR. G. H. Fox for DR. GRAEME M. HAMMOND.

The patient was an old colored woman, a native of Bermuda, where she had resided until recently. The case was originally diagnosed as one of cerebro-spinal sclerosis, but the *facies*, the condition of the hands and the existence of an anesthetic patch on the leg left little doubt that the case was one of leprosy. There was also an ulcer on the sole of one foot.

A Case for Diagnosis.—Presented by DR. MORROW.

The patient was a middle aged woman with lesions of the left hand and forearm. The eruption first made its appearance about

twelve years ago, and gradually spread over the entire palm, dorsum, and both aspects of the wrist, reaching its present extent about five years ago. At first it had the appearance of a ringworm, now it is suggestive of erythema. There has never been any exudation nor have any vesicles formed. The nails have never been affected. The woman has never had any constitutional disease nor nervous trouble. There is no specific history. There is nothing abnormal in the urine. The case was presented for diagnosis with the suggestion that it might be an example of lupus erythematosus.

A Case of Tertiary Syphilis.—Presented by DR. SHERWELL.

Dr. Sherwell said the only reason for presenting this case was in that it afforded such exemplification and confirmation of Dr. A. R. Robinson's text, in his late address before the American Dermatological Association, in regard to the necessity for the surgeon, and general practitioners consulting dermatological experts, in doubtful cases. Here was a man over fifty years old with syphilitic history, freely admitted on inquiry; lesion on forehead, undoubtedly from patient's description, etc., a late solitary gumma. This had been diagnosed and treated as a cancerous growth; escharotics freely and repeatedly used, with ever increasing size of lesion. Under mild constitutional treatment, and very mild local calomel ungt. (grs. x to $\frac{3}{4}$ i), and strapping, the present almost perfect cure had resulted in five weeks. He had been under treatment by the other means for over a year.

A Case of Multiple Tumors of the Skin for Diagnosis.—Presented by DR. KLOTZ.

The patient, thirty-eight years, Russian Hebrew, a shoemaker, gives a history of the appearance of numerous small lumps in the skin since his eighth year; a cluster of nodulated tumors on the left side of the nose having been in existence since birth. The tumors are distributed principally over the back, chest, shoulders, and arms. Some of them are situated underneath the skin in the subcutaneous tissue; they are quite hard and large, reaching on some localities the size of a walnut. Others are softer, and more or less pedunculated, greatly resembling the common type of fibroma molluscum or pendulum. By far the largest number develops in the skin itself, protruding but slightly above the surface. They are of smaller size, from that of a hemp-seed to a lentil or a large pea, of a brownish-pink color, well defined, flat and of moderate consistency, representing some features of the epithelioma benignum as described by Dr. Fordyce. The general health of the patient has not been affected by the presence of the tumors, only recently he has lost somewhat in strength, since the small tumors have developed in much larger number. So far it has not been possible to remove any of the new growths for microscopical examination. They do not cause any pain or other sensation, except on some places where they are exposed to pressure.

DR. LUSTGARTEN said that some of the growths were very similar to those of molluscum fibrosum. He was inclined to believe, how-

ever, that the majority would prove to be cystic or benign epithelioma.

DR. ROBINSON diagnosed the case as one of multiple fibroma.

Dr. G. H. Fox said that from the appearance of the tumors and the history of their development, he was inclined to regard them as fibromata.

DR. ALLEN said he thought the case was one of molluscum fibrosum in a man who had a congenital predisposition to such fibrous outgrowths. The patient stated that as long as he could remember he had had the lesions, which were noticeable, by the side of his nose.

DR. J. A. FORDYCE said he was convinced that the majority of the lesions would prove to be benign epithelioma. It was possible that some of the subcutaneous growths might be molluscum fibrosum, but those on the chest certainly did not have that appearance. The speaker said he reported a very similar case some years ago.

A Case of Peculiar Ringed Eruption, Probably Lichen Planus.—Presented by DR. P. A. MORROW.

The patient was a middle-aged woman, who stated that ten years ago she had been treated at Hamburg with chrysarobin for psoriasis. Four or five years ago she had another slight attack, which soon disappeared. Her present attack began last autumn, the lesions appearing as separate papules. Rings began to form in the past spring. She states that there was no scaling at first, but as she used ointment on both legs, her observation may not be correct. The lesions are confined to the outer and anterior aspects of thighs and legs; they do not extend above the middle third of the thighs. She has employed Unna's ointment, white precipitate ointment, and chrysarobin, and has taken arsenic internally, with no marked improvement.

DR. LUSTGARTEN regarded the case as one of lichen planus, with serpiginous and annular lesions. Dr. Robinson made the same diagnosis; also Drs. Elliot and Klotz. Dr. Bronson said the case was certainly not one of psoriasis; it looked more like lichen planus. Dr. T. Colcott Fox thought the case was probably one of lichen planus.

A Case of Epidermolysis Bullosa.—Presented by DR. GEORGE T. ELLIOT.

The patient was a young man who gave no hereditary history of the disease. Scattered over the body were numerous bullæ and the scars left by previous lesions of the same character. These patients, the speaker said, are more comfortable in cold than in warm weather.

The Germans claim that in all these cases there is a hereditary history; in this case, however, although the disease has existed since birth, no history of heredity is obtainable. Several years ago, Dr. Elliot said, he presented another case of this disorder which was likewise the first instance in the family. In the latter example he knew the man's family and antecedents. Those who claim that there is always a hereditary history forget the fact that there must be some time when a case of epidermolysis bullosa must begin.

DR. LUSTGARTEN said he did not regard the case as a typical one of epidermolysis bullosa, as the patient showed such marked nervous symptoms. The latter seemed to point to some central nervous lesion.

DR. T. COLCOTT FOX referred to the nervous symptoms exhibited by the patient, which he regarded as very interesting. Two or three years ago, at the Nottingham Infirmary in London, a man with a bulbous eruption was under observation for some time. It was thought to be a chronic pemphigus, but it turned out to be a case of syringomyelia. A report of the case was published in the transactions of the Clinical Society.

DR. BULKLEY said this patient had been in the hospital for six or eight months, where he had watched the case. For several months he had been treated by applying ice-bags to the spine, but the lesions made their appearance during the course of the treatment. Numerous other remedies had been employed, with little or no resulting benefit; the bullæ developed in various places, with the least irritation or of pressure on the skin.

DR. ELLIOT, in closing the discussion, said that in this case the disease manifested itself shortly after birth. The trembling and nervous symptoms were of comparatively recent development. The speaker said he would not be surprised if the autopsy in a case like this would prove that it was one of syringomyelia.

A Case of Macular, Melanotic Sarcoma Cutis.—Presented by DR. LUSTGARTEN.

The patient was a woman who had already been presented by him some time ago. At that time she had a pigmented patch on one side of the face, in the region of the forehead, which had since extended down on the cheek; there was also considerable pigmentation of the sclerotic and about the optic nerve of the right eye. The speaker said he had thus far been unable to make a microscopic examination, but the case was probably one of sarcoma cutis of a particularly mild type. The only similar case he knew of was one published by Dr. Robinson.

Paget's Disease.—Presented by DR. LUSTGARTEN.

Woman of forty-two; left nipple attacked. Began two years ago. There is total absence of eczematous changes, but a superficial gyrate infiltration surrounding three-fourths of the circumference of the nipple. The latter is enlarged and somewhat indurated, and shows beginning retraction. The microscopic preparation, which is demonstrated, shows besides the epitheliomatous structure a great many of the peculiar bodies, which first by Malassez and Albarran, and then by Darier and Wickham, were considered to be psorosperms, by others peculiar cell degenerations. However that may be, these bodies seem to be characteristic enough, and deserve attention in the question of microscopical diagnosis of Paget's disease.

DR. SHERWELL said that in a large number of the cases of pigmented sarcoma, there is present pigmentary deposit in the sclerotic of the eye. In one case coming under his observation, the uveal tract seemed to be implicated.

The speaker said he did not regard the second case shown by Dr. Lustgarten as a typical one of Paget's disease. The eczematous condition, which is so usually present, was not very marked. Furthermore, the nipple seemed to be almost hypertrophied, rather than

diminished in size, as we should expect in a case of three years' duration.

DR. DANIEL LEWIS referred to a case of melanotic sarcoma of the cornea coming under his observation some years ago. He removed not only the eyeball, but also the entire contents of the orbit, and there was no recurrence of the disease, the patient dying several years later of old age.

A Case of Adenoma Sebaceum.—Presented by DR. G. H. FOX.

The patient was a little girl with numerous small, reddish telangiectatic tumors on the face. The speaker said this was the third case of this character presented by him to the Society within the past year. At the International Dermatological Congress held in London last summer, a number of similar cases were shown under the above name.

DR. T. COLCOTT FOX said he hardly knew whether to classify this as a case of adenoma sebaceum. If so, it certainly was not a very well marked one. The affection known as adenoma sebaceum is quite common in England, and is chiefly met with among the children in imbecile asylums. It is sometimes difficult to differentiate from those cases in which the face is covered with pink, flat warts.

A Case for Diagnosis.—Presented by DR. FORDYCE.

The patient was a male, German, fifty-four years of age; a machinist by occupation. He denies ever having had syphilis. Two years ago he had an attack of rheumatism, for the relief of which he employed some liniment. Soon afterward an eruption appeared over the anterior portion of one leg, which gave rise to considerable itching. The eruption extended by the formation of papules, which rapidly increased in size. The papules were followed by warty growths. Four weeks later the skin of the penis became red and itchy, and a similar papular eruption formed, which gradually assumed its present appearance. Nine months later the same process made its appearance in the left popliteal space, terminating in the same manner. Within the past two months the skin over the scrotum became involved.

A great number of small, flat-topped papules are present, surrounding the warty infiltrated patches on the lower extremities, which suggest the lesions in lichen planus.

DR. G. H. FOX regarded the case as one of lichen planus.

DR. BRONSON said he did not think it was a case of lichen planus. Such hypertrophic lesions as were present in the case might be the result of the long continuance of an inflammatory disease, the nature of which was here not clearly apparent.

A Case of Mycosis Fungoides.—Presented by DR. LUSTGARTEN.

The patient was a man who had enjoyed good health up to eighteen months ago, when he begun to suffer from an eruption which first appeared on the arms and then spread to the face and body. In appearance, the eruption resembled an eczema and gave rise to considerable itching. The speaker said he regarded it as a case of mycosis fungoides in the eczematous and lichenoid stage.

DR. G. H. FOX said he preferred to wait before making a posi-

tive diagnosis in Dr. Lustgarten's case. He referred to a case of mycosis fungoides in the eczematous stage which came under his observation at the Skin and Cancer Hospital, in which there was a generalized eczema which lasted for nearly a year and resisted all forms of treatment. Later, the development of the characteristic tumors made the diagnosis of mycosis fungoides certain.

A Case of Dermatitis Papillaris Capillitii.—Presented by DR. BRONSON.

The patient was a man, and the disease was confined to the nape. It had first appeared several years ago, but disappeared again almost entirely. Within the past six months it had recurred in the same situation as before.

A Case of Syphilis of the Palms.—Presented by DR. MORROW.

The patient was a man advanced in years. He had an eruption on the palms of the hands, which first made its appearance nine years ago. It began at the inner edge of the palms and gradually spread. The man denies syphilis. For some months he was treated with antisypilitic remedies, both internally and externally, and the palmar lesions rapidly disappeared, only to return later. More recently he has been treated by means of injections of calomel, without local applications, with good results.

Dermatitis, etc., from X-rays.—DR. ELLIOT said he had recently learned some interesting facts regarding the effects of the X-rays. At an exhibition of the rays, two boys were engaged to pose, and every day a dozen or more séances were given, during which the X-rays were thrown upon them so as to show the ribs and sternum. After a duration of two or three weeks, the skin covering the area which had been exposed to the rays became superficially sphacelated, the lesions being similar to those produced by a burn. They readily healed by granulation under simple treatment.

Dr. Elliot said he had also heard of a case where the frequent exposure of a certain portion of the scalp gave rise to complete baldness in that area. The speaker referred to certain experiments which showed that sunburn was not due to the heat rays of the sun, but to the chemical, and particularly the violet, rays. By cutting off the latter, he showed that there was no burning effect on the skin whatever. When we bear in mind that from Crookes' tubes a large number of violet rays are emitted, we probably have the explanation of the cauterizing effects of the X-rays on the skin.

DR. PIFFARD said that almost since the introduction of the Röntgen rays it had been considered possible that exposure to them might give rise to physiological effects, and recently, from many directions, facts which have come to light tend to confirm that possibility. The cases related by Dr. Elliot were the most striking that have thus far been brought to his attention, and they should warn us not to tamper with the X-rays until their exact physiological effects have been ascertained. Dr. Elliot spoke of the X-rays as being violet rays. They are not violet rays. Whether they are ultra-violet rays or not, we cannot to-day say. It has not been proven, and just what they are is not known. The difference between the violet and ultra-

violet rays and the X-rays resides in this: The violet and ultra-violet are refrangible, while the latter are not. The statement made by Dr. Elliot that by cutting off the violet rays we cut off heat is also incorrect. Over fifty years ago, John W. Draper showed that the heat rays chiefly resided at the least refrangible end of the spectrum, namely, in the ultra-red. The speaker said he was familiar with the experiments alluded to by Dr. Elliot, where all the rays were excluded but the red or violet. In putting in red glass, you may exclude also the ultra-red, which are more powerful than the red. The induction he had drawn from those experiments was that sunburn was not entirely due to the heat effects of the sun.

DR. ELLIOT, in closing the discussion, said that Dr. Piffard had misunderstood him. He did not state that the X-rays and the violet rays were the same; on the authority of Professor Bucks, of Providence, he had stated that there were a great many violet rays given off from the Crookes' tube. Furthermore, he did not state that the violet rays and the heat rays were the same; he made a distinction between the heat rays and the chemical and heat rays. He said that sunburn was the result of the chemical rays, not the heat rays.

NEW YORK ACADEMY OF MEDICINE.

SECTION ON GENITO-URINARY SURGERY, NOVEMBER 10, 1896.

F. K. OTIS, *Chairman*.

Treatment of Strictures of the Male Urethra.—DR. J. A. WYETH, the author of the paper, stated that he would deal only with organic strictures, those due to cell proliferation under the stimulus of an infectious inflammation. He divided the strictures of the urethra clinically into, first, those affecting the anterior half-inch of the urethra; second, those between this point and the bulb; third, those affecting the bulbo-membranous portion of the urethra. True organic stricture in the first class is not common, is limited, and easily corrected by operation. In his experience the usual cases had been due to traumatism or corrosive applications. As a rule, he incised them along the middle line of the floor, but divided on the side or roof if necessary, and practised interrupted dilatation.

Treatment of those in the second class consisted in internal urethrotomy, or incision with modified divulsion. The Otis urethrotome was introduced, cutting in the middle of the roof. Stretching the stricture fairly well, he passed the knife backward and forward in the same groove once or twice. Then the blades were separated further and stretching was practised if the stricture yielded easily. If there is further resistance the bars are separated to the point of resistance, and the knife again drawn through. In case it is found impossible to pass the urethrotome, he began with the dilating filiform bougie of Banks, a most useful instrument.

Stricture of the bulbo-membranous portion is much the most intractable to treatment. In rare cases where the dilating filiform

bougie would not pass, where there is abscess or urinary fistula, he performed external urethrotomy or perineal section. A large portion of the strictures of this part can be relieved by a modification of the internal cutting operation. In the last ten years he had not met with a case in which this procedure was not indicated. Moreover, he was convinced that perineal urethrotomy is often done where milder measures will succeed. His method is as follows: Provided that the stricture will not admit the urethrotome, he injects the anesthetized urethra with sterilized sweet oil, forcing a small quantity through the obstruction. As is well known, the cut off muscle yields readily to over-distension of the channel. The dilating filiform is then introduced, and the stricture gently dilated until it admits the urethrotome, the straight instrument being used as for the anterior portion. It may require a little gentle force to secure its passage. After two or three minutes the cut-off muscle releases its grip upon the instrument, after which a better idea of the character of the stricture can be made. The knife is drawn from behind forward without separation of the bars along the roof of the urethra, and if the bands yield readily under gentle pressure, divulsion is practised, the connective-tissue fibers yielding in the line of the partial cut. In case the instrument catches as the screw is turned, the effort at stretching should be stopped, the blades approximated, then separated slightly, and the incision repeated.

He claimed this advantage for this modified method of divulsion: The surgeon is able to select intelligently the line of cleavage, while in ordinary divulsion without cutting, it is a blind tearing in any direction. After stretching in the manner described, interrupted dilatation is continued. For this purpose he preferred the straight sound to the curved, and in case the stricture was dense it might be necessary to pass a sound once or twice a month to prevent a recurrence. If the stricture recurred early, and required such attention as to be annoying to the patient, perineal section may be advised. The author gave the details of his methods of sterilization of the urethra and urine. He accomplished the first by irrigation. In the latter instance he administered twenty drops of a mixture of 3 ii of oil of gaultheria, and 3 i of salol, three or four times a day. Locally he irrigated with permanganate of potash (1 to 3000) for a few minutes before the operation, and ballooned the canal three or four times under sufficient pressure to overcome the cut-off muscle. Anesthesia might be accomplished by using one to three drams of a 2 to 4 per cent. solution of cocain. Anesthesia of the membranous portion can be secured by injecting the cocain solution through an Ultzmann syringe, carrying it down to and slightly within the cut-off muscle. Beyond the compressor, anesthesia was practically impossible, on account of the dilution with the urine. Hemorrhage he controlled by external pressure. He had not used electrolysis, for the reason that he did not think the electrical current could dissolve cicatricial tissue without itself leaving a scar.

DR. R. W. TAYLOR has never seen stricture of the meatus produced by ordinary injections. He found it due to chancre or chan-

croids. He is entirely opposed to over-distention in the treatment of stricture. Of late years a good many cases of curved penis have been seen, due, in his opinion, to turning up the urethrotome, over-distention doing more damage than the cutting. The secret of success is in the after-treatment. The Fort method of electrolysis gave good results in strictures of the pendulous portion, not of great density. In strictures of the bulbo-membranous junction it often succeeded where formerly he would have resorted to external urethrotomy. A great deal may be done with this instrument, but, like all others, it should not be used in every case.

DR. SAMUEL ALEXANDER agreed with Dr. Wyeth entirely regarding strictures in the anterior portion. The most satisfactory method of dealing with strictures in this part was to divide them by internal urethrotomy. For strictures at the bulbo-membranous portion he seldom resorted to cutting, but, following the practice of his teacher, Dr. Keyes, dilated them. Relapse occurred about as often as after division. The intervals between dilatation should be five or six days at least, and if the patient could not spare the time he used the cutting instrument. In broad, deep strictures he preferred external urethrotomy. Regarding sterilization, he irrigated with permanganate of potash (1 to 5000 or 6000); internally he administers oil of wintergreen, but sterilization of the urine is secondary in importance to that of the urethra.

DR. CULVER was formerly in the habit of dilating until a large sound could be passed, but now thought No. 26 was large enough for any urethra.

DR. SWINBURNE had been afraid to incise deep strictures at the bulb, and resorted to sounds instead. By sterilization of the urethra he found less and less necessity for instrumentation, and when the latter becomes indispensable it is much safer after antiseptizing the urethra.

DR. VALENTINE said that he had treated ten cases with Fort's method, two of which were failures and eight successful. He was surprised to hear that Ultzmann contented himself with raising the urethral caliber up to No. 26. Those who followed Oberländer had little reason to complain of their results.

DR. KLOTZ did not agree with Dr. Taylor that all strictures at the meatus are due to chancre or chancroids, but thought that they might follow the use of the syringe, etc. Over-dilatation in the anterior portion makes the urethra sac-like, and destroys its elasticity and expulsive power.

DR. EUGENE FULLER believed that too much stress had been laid on the cutting methods, but enough care had not been taken to ascribe importance to other methods. There is a place for cutting, especially in the deep urethra, but in the penile portion it requires great care. Resection might have been given greater consideration in some cases. Dr. Wyeth, in closing the discussion, said that the method described had given him as good results as any, with a minimum loss of time.

Book Reviews.

Diseases of the Skin. GEORGE THOMAS JACKSON, M.D. Second edition. Lea Brothers & Co., New York and Philadelphia; 1896.

The value of Dr. Jackson's handbook and the success which has attended its sale cannot be better attested than by the early issue of its second edition. It is not more than two years since it was reviewed in these pages, and we extend our congratulations to the author on the fulfilment of the prediction then made for it.

The opportunity has been seized to enlarge and enrich this work with the results of recent discoveries, such as Sabouraud's in tri-cophytosis, and by adding new chapters on diseases not previously considered. Among the latter are feigned eruptions, hydroa vacciniforme, erythema induration, benign epithelioma. Some idea of the scope of the treatise may be formed from this list. The consideration of seborrhea has not, however, been freed from its confusion. Unna's and Elliot's best work has been incorporated in the article on eczema seborrhoicum, but in spite of this the line of demarcation is not clearly drawn between it and seborrhea oleosa. The author holds that no positive proof has been adduced to show that the oily variety is not entitled to a place as a clinical entity. Dr. Jackson's paragraphs on treatment are admirable, and after all that is the student's end and aim, not fine points in diagnosis. J. C. J.

Diseases of the Rectum and Anus. S. G. GANT, M.D. The F. A. Davis Company, Philadelphia; 1896.

The author has the assistance of H. W. Allingham, who wrote the chapters on cancer and colotomy. The consideration given to diseases of interest to the readers of the JOURNAL is too short to be of any value. Any work on syphilis will contain more than four pages on the rectum. Pruritus ani falls short in the same way, although a valuable hint is given as to the etiological rôle of superficial ulcerations. A point of genuine interest is Dr. Welch's opinion regarding the pathogenetic significance of the *colon bacillus*. Much has been attributed to it, he says, which should be laid at other doors and the reasons it is so often found are that its tenure of life is great, it is present when other organisms have disappeared, and it can readily be cultivated on all media and at all temperatures. The book is profusely illustrated.

Physician's Visiting List. P. Blakiston, Son, & Co., Philadelphia; 1897.

Valuable additions are being made to Blakiston's list every year. It is full of information of value in emergency, in addition to the good arrangement of blank inside pages for accounts, addresses, births, deaths, etc.

Syphilis in the Middle Ages and in Modern Times. Vols. ii and iii. F. BURET. Translated by A. H. OHMANN-DUMESNIL. The F. A. Davis Company, Philadelphia; 1895.

Interesting reading this volume is without a doubt; as to the profit there is no such certainty. Vols. i and ii, it may be remembered, are devoted to proving the existence of syphilis in prehistoric times, and to tracing it to the Naples epidemic in 1493. The effort is as futile as others have been; there may be no doubt in one's mind that venereal disease did exist, but proof of its syphilitic nature does not and cannot in the nature of things exist. As a study of sexual morality in early eras (Nineveh even has its share of space), it is vastly interesting. One can readily understand that it required three years to gather the material when the brick cylinders of Babylon as well as volumes from medieval presses have given their quota to enrich it. The legends are vastly interesting in themselves, aside from their pornographical features.

Vol. iii deals with the disease in its historic career since the middle of the fifteenth century. Here we are on surer ground, and the work is of real value. The translation is as smooth as the original French.

J. C. J.

Selections.

GENITO-URINARY DISEASES.

Abortive Treatment of Gonorrhea. DR. J. JANET (*Ann. d. mal. d. org. gén.-urin.*, 1896, p. 1013. Third day of meeting of the French Assn. of Genito-urinary Surgery).

In discussing the question of the abortive treatment of gonorrhea, Janet believes that since the discovery of the gonococcus we have been obliged to alter our ideas as to the etiology of the disease, and therefore also our conception of what constitutes the abortive treatment. Before the discovery of the gonococcus we had no means of making any distinction between the different forms of urethrites, especially at the onset of the trouble, and it is doubtful whether a case of true gonorrhea was ever successfully aborted, in the sense of the older writers when they claimed to have done so.

For instance, Diday used to insist upon the importance of attempting to abort a gonorrhea while the discharge was still mucoid in character, believing that after it became purulent it was too late to make the attempt. J., on the contrary, states that out of large numbers of cases which have come to him at the earliest symptoms, those in which the discharge was mucoid in character were never found to contain gonococci, though the patients came believing that they had contracted gonorrhea. On the other hand, those cases in which the discharge was found to contain gonococci, were always purulent, no matter how quickly after the first symptoms they appeared.

Further, from our present knowledge it is probable that during the period of incubation, the penetration of the epithelium, and even the sub-epithelial layer, by the gonococcus, is an important fact, though the extent of surface affected may not be great. It was this fact that led J. to propose a treatment (now well-known) which in theory differs but slightly from one which was found to be useful at a later stage, and in the strictest sense this is not a true abortive treatment, for such a treatment, in view of what we now know, can only be applied within a few hours of an infection, *i. e.*, before the diagnosis can clinically be made, and hence becomes confounded with the prophylactic treatment.

J. gives his reasons for not giving statistics, but sums up the general impression which he has of the value of the abortive treatment by permanganate of potassium. He claims that in every case in which he has used this treatment before the acute symptoms have manifested themselves, among which swelling of the urethral mucous membrane is the most important, he has been able to attain the absolute suppression of the gonorrheal process, and from the beginning of treatment up to the time of complete cure, not one of the patients showed any increase of invasion by gonococci. During the entire treatment the discharge was insignificant, and none of the cases showed a single complication usual in this disease.

This result is attained in a treatment lasting eight to twelve days, if seen before the acute symptoms appear, if the patient is regular in attendance, abstemious in his habits, if the existence of an extra-urethral focus of infection close to the meatus is not overlooked. If, however, any oversight of this kind occurs, or any irregularity on part of patient or physician, the cure may be retarded from two weeks to two months, but during this time the evolution of the gonococcus is retarded, the lesions which they may cause in the urethra are suppressed; every chance of complication in the present and future is removed, and the patient at the end of his treatment, even though it last two months, finds his urethra anatomically in as healthy a condition as before his attack.

As splendid as these results are, J. believes that the treatment has its limitations; it is a luxury, inapplicable to the hospital, and hardly likely to become generalized; (1) because few patients are able to spare the time or expense; (2) because only the specialist can conform to the severe regularity.

It may, however, be considered as the method of choice in those cases in which it is applicable and in the hands of those able to conform to its exigencies; but for those other cases in which this treatment is inapplicable, J. wishes that there might be some treatment which could be offered, even if at the risk of an unsuccessful issue in some instances, which would give the chance of a more prompt and rapid cure. And he asks whether those procedures depending upon large doses of the balsams, the employment of nitrate of silver or sublimate by injections, are radically useless and ought definitely to be dropped, or whether they are of value. He expresses himself as being so well satisfied with the results obtained

by his series of irrigations with the permanganate that he has not ventured to return to these older methods to prove their efficacy or inefficacy, but wishes that their effects might be carefully studied in those cases in which the presence of the gonococcus has been authoritatively found to be present.

Dr. Vigueron (of Marseilles) has used permanganate according to Janet's method for five years. Its employment he found strikingly successful in those cases coming within the first thirty-six hours of their disease. Such cases are rare; he had had only twelve. Of these twelve, nine were absolutely cured in six to ten days. In these, there were daily examinations for the gonococcus, and treatment was continued two days after the gonococci had disappeared; they were watched for fifteen days and there was no return of the trouble. In one case he gave no lavage on the day on which he found no gonococci, in forty-eight hours they redeveloped, and it took eight days to cause their disappearance. The two remaining cases took fourteen days of irrigation.

In these cases which had lasted a longer time before coming, but which were without complication, he had been able to cause a disappearance of the gonococcus in from fifteen to thirty days, but there was apt to remain a sero-mucous or a sero-purulent moisture, which compels a continuance of treatment either with this or some other solution.

He finds that the lavage is well borne, not causing too much pain. In only one case did epididymitis occur; that was in a patient who had passed an evening in gay society after riding horseback during the day.

Dr. Guiard (of Paris) agreed with Janet and Vigueron as to the remarkable efficacy of the permanganate in the treatment of gonorrhea, but he differed from them as to dosage and method of application. He had found that the dosage, as recommended, produced too violent a reaction and was followed by excessive pain; he had reduced the strength to 1-10,000, up to 1-6000, and had been surprised to prove: (1) That the gonococci disappeared more quickly than with the stronger dosage; (2) that the pain produced was insignificant; (3) there was no secretion due to the reaction, and the result was more satisfactory and more encouraging. Hence he had become an advocate for the weaker solutions, with which he had obtained a rapid and definite cure, in several cases with six or seven irrigations, though usually ten to twelve are necessary. G. reports the case of a man fifty-seven years old, neurasthenic, who had a chronic discharge for twenty years, and had recently received an acute reinfection containing gonococci. Even a strength of 1-10,000 produced severe pain, the use of cocain giving no relief against it, and at the end of five days the patient refused to continue treatment; but the gonococci had disappeared after the first lavage, and at the end of a week the discharge had completely dried up and remained so for the first time in twenty years.

The second point on which he differed was the method employed; he prefers a large syringe (holding several ounces) to the

irrigation apparatus. The method employed by him has been described in the *Annales des gén.-urin.* for September, 1896. He believes that with the hand syringe the slightest resistance is more quickly conveyed to the operator, pressure may be more quickly relieved, and the method can be more efficiently and more gently employed than can irrigation by pressure.

Finally, this treatment succeeds best in those cases where it is begun before the fourth day, except in certain cases which appear to have a certain resistance to the invasion of the gonococcus, and after this the treatment is of but little use until the end of a month, and then from that time on the older the trouble the more efficient this method becomes. G. believes that, as a rule, if the disease has lasted longer than four days it is better to have recourse to the treatment laid down by Fournier, baths, bicarbonate of sodium internally, and the balsams in sufficient dose.

Dr. Noguès (of Paris) finds the permanganate of greatest use in the earliest stages, before the acuter symptoms occur. As soon as the prepuce and lips of meatus become edematous, urination painful, and painful erections occur, he believes this method should not be employed; he finds it tedious and unsuccessful in the majority of cases. He had employed Janet's method in eighteen cases, coming within the first few days of their discharge; in all of which the presence of the gonococcus was established. Of these, seven were cured in from one to twenty-three days; in the remaining eleven cases the discharge rapidly diminished but persisted, the gonococci remained, and when the irrigations were interrupted the discharge returned and was as profuse as when no treatment was used. N. believes, however, in lavage, and prefers the irrigator to the syringe; he employs the permanganate in strength from 1-4000 up to 1-500, but 1-500 should be used only in the anterior urethra. He irrigates at intervals, at first, of twelve, then eighteen, then twenty-four hours, irrigating the anterior urethra by sections, and in all cases the treatment is extended to the posterior urethra. He thinks, though, that it is a mistake to confine ourselves too persistently to one drug; the permanganate is of great use in many cases, but it also fails. One case which had resisted a long series of irrigations with the permanganate, was cured after two irrigations of nitrate of silver in solution of 1-2000. In two cases the oxycyanide of mercury gave brilliant results.

Dr. Guiard recalled several cases in which two or three irrigations of nitrate of silver or sublimate solution had caused the immediate disappearance of the gonococcus after ten to fifteen irrigations of the permanganate had failed. On the other hand G. has several times endeavored to react against too absolute an opinion that sublimate and nitrate of silver have the property of exciting the multiplication of the gonococcus, seeing that the nitrate has enjoyed a vogue, not unmerited, as being of use in urethral gonorrhea, and especially of use in gonorrheal conjunctivitis.

In experiments with the permanganate of calcium, and the bichromate of potassium, and even with sublimate, G. has found the

gonococcus to persist while using these drugs, and promptly to disappear after changing to the permanganate of potassium; he believes that up to the present time no other drug approaches the permanganate of potassium as an antiblennorrhagic.

Dr. Evand (Lyons) does not think that Janet's method merits the name abortive treatment. It modifies the period of suppuration, diminishes and changes the character of the secretion, diminishes the number of gonococci, but it seems to him that this is counterbalanced by a lengthening of the period of decline, which is always a long period and a dangerous one to the patient, and if we make a comparison between gonorrhoeas treated by this method and those treated by the classical method, it is difficult to say to which side the balance weighs. For to declare a gonorrhea cured it is necessary to obtain complete absence of secretion, the disappearance of every gonococcus. Unfortunately to-day we know the frequency of latent gonorrhea, and what reason we have to fear an awakening of the gonorrheal process. E. further believes that other substances are as good as permanganate: as sublimate, methyl blue, gentian violet, and other aniline colors which have an action more marked than permanganate against the gonococcus. After all, however, he believes that large irrigations of the urethra with permanganate or other substances in weak solution and non-irritating to the urethra render great service; that they lessen the tendency to orchitis and prostatitis, but he protests against irrigation of the posterior urethra as a useless procedure.

Dr. Desnos (of Paris) employs the permanganate by a method of his own; he does not believe that the abortive treatment necessitates lavage of the entire urethra; in the beginning we may limit ourselves to the anterior urethra, and believes it well to spare the posterior urethra as long as possible. He prefers the syringe to the irrigator, and makes his strongest solution at the start, but he always leaves the canal open, allowing free escape of the solution. He begins with 1-500, and passes 4 to 500 grams of the solution slowly, keeping the meatus open. In twelve hours this is repeated; the next day he employs 1-1000, unless there was too violent a reaction from the previous day, when he uses a weaker solution; on the third, fourth, and fifth days the strength employed is 1-5000. Employed in this manner within thirty-six hours of the beginning, this treatment has given D. seventeen cases of success out of eighteen. The gonococcus sometimes disappears after the first lavage, ordinarily after the second and third, and does not return. In seven cases all secretions disappeared by the fifth day.

Dr. Guiard thought the failures which M. Evand had were probably due to the fact that he only irrigated the anterior urethra, and thinks no portion of the canal should escape treatment. He thinks it impossible to have serious doubts as to the fact that the cures are positive, as the patients are subject to control experiments. After the regular treatment of eight days, during which ten to twelve irrigations have been given, he has the patient return in five days. This is the average time of incubation of the gonococcus. Then, if

the examination is satisfactory, the patient is then allowed to drink beer and disregard strict rules of hygiene, and if the gonococcus has not disappeared it will remultiply under this regimen. Then, too, the patient is not pronounced cured if there is any secretion or any filament or grumous material in the first urine passed on awaking.

Dr. Janet agrees with Guiard as to the efficacy of weak solutions of the permanganate. He regards the irrigation of entire urethra as important, though it may be omitted for the first day or so. Yet the gonococcus must be ferreted out at every point or the procedure can only lead to failure. Some one mentioned antiphlogistic treatment in the beginning; this was the very period of acute gonorrhea that those lesions were produced which lead to complications. J. declares that in five years he has not observed a single case of stricture among the cases treated by his method, and asks, Can the partisans of the antiphlogistic treatment say as much?

[So far as this treatment is inapplicable to a dispensary practice is concerned, the reviewer has not had cause to regret the three years during which this has been almost the only method pursued, though under the limitations which necessarily accompany a dispensary practice, and far from avoiding the use of this treatment during the acute symptoms and in the presence of complications, these have been the very cases in which marked successes have been scored, due care being taken not to use any but the weaker solutions during the severer symptoms.]

G. K. S.

The "Capacity" of the Posterior Urethra. (*Archiv für. Dem. und Syph.*, Band xxxiv, Heft 3.)

Guyon and Ultzmann maintain that even the smallest amount of liquid injected into the posterior urethra enters the bladder. Guiard and Von Antal found that about five drops, Posner and Goldberg that two to three cubic centimeters, could be injected without entering the bladder. Dreysel confirms the experiments of Posner and others, but does not share the conclusions drawn from these experiments, that there is a capacity of the posterior urethra. He maintains that even a few drops of liquid—he injected *experimenti causa* a solution of methylene blue—deposited in the posterior urethra, will mix with the contents of the bladder, but leaves it undecided whether they enter the bladder spontaneously or whether they are "pressed" into the bladder through a reflex contraction of the walls of the posterior urethra.

The Reaction in the Canal of the Urethra. (*Idem et ibidem.*)

Formerly the opinion had been prevalent that acid urine is unfavorable to the development of the gonococci. In accordance with this view, Brewer, in Morrow's "System of Genito-urinary Diseases," page 149, thinks that the urination after coitus, which is recommended as a preventive of gonorrhea, "acts more by restoring the acid reaction of the canal than by any mechanical removal of pathogenic organisms." Finger, however, showed that the gonococcus

thrives better on an acid medium, so that the acidity of the urine is rather favorable to the gonococcus. Jadassohn introduced litmus paper which was attached to a soft, thin bougie, into the urethra, and found that the reaction of the normal urethra is nearly always alkaline, sometimes neutral, but never acid. Even after the patient had passed a strongly acid urine, the reaction in the urethra was generally found alkaline. In such a case the reaction remained alkaline even after injecting acid urine into the urethra and leaving it in the urethra for five minutes. The alkaline reaction is due to the secretion of mucus and to the osmosis of lymph. This being continuous, the reaction is always alkaline. The acidity of the urine is not sufficient to neutralize the alkalescence of the mucous membrane, either because the contact is of too short a duration or because the urine does not contain enough acid for that purpose. In gonorrhea the reaction was always found distinctly alkaline, even after micturition.

GOLDENBERG.

A Case of Exitus Letalis, Eighteen Hours after the Passage of a Sound into the Urethra. DR. F. MÜLLER (*Centralbl. f. d. Krankh. der Harn- und Sexualorgane*, Band vii, Heft 3).

The patient, thirty-eight years old, was perfectly healthy except for a slight difficulty in urination and cloudy urine. Diagnosis: Cystitis, strictura p. membranaceæ. Two metallic sounds, previously disinfected, 21 and 23 F., were used *lege artis*, but did not pass the stricture. Moderate bleeding after sounding. Three to four hours afterward chills, pain in the lumbar region, general malaise; no suppression of urine. Death eighteen hours after the sounding.

Post-mortem examination showed slight superficial erosion at the site of the stricture, no traumatism of any importance, no urinary infiltration. The prostate contained a large amount of pus; mild degree of fatty heart; very slight macroscopical changes in the kidneys, "probably acute nephritis." A microscopical examination was not made, as a piece of the kidneys reserved for that purpose was lost. Altogether the autopsy did not explain sufficiently the cause of death. (It seems to me that not sufficient stress is laid upon the suppurative process in the prostatic gland, and on the possibility of absorption and general infection therefrom.)

GOLDENBERG.

Castration for Enlarged Prostate. MOULLIN (*Lancet*, February 8, 1896).

The author operated on twelve cases with retention and cystitis. Two died from heart failure and apoplexy. In all cases improvement was noted in a few hours; in all but one power of voluntary micturition was regained, and residual urine fell below two ounces. There was in ammoniacal cases a disintegration, loosening, and passage of the deposit formed on the bladder walls as the urine became normal. Two men suffered from a form of traumatic delirium not referable

to the immediate operation shock, to septicemia or uremia. Recovery followed in both instances. The author thinks this disturbance dependent on the operation, but it seems probable, in view of testimony adduced at the meeting of American genito-urinary surgeons, that it may be a form of mania occurring in the course of the disease, whether castration is performed or not.

Subacute and Chronic Cystitis treated by the Vesical Balloon.

J. G. CLARK (*Johns Hopkins Hospital Bulletin*, Nos. 59 and 60, February-March, 1896).

The apparatus consists of a small balloon of thin rubber, six centimeters in diameter, collapsed, connected with a thicker rubber tube, twenty-six centimeters in length, with a small cut-off valve. Any cheap pump (bicycle) may be used for inflation. It is smeared with a ten-per-cent. ichthyol gelatin in place of oleaginous ointment, and is soon destroyed if not carefully cleaned. Before using, the balloon is boiled and placed in a boric-acid solution. After determining its capacity and cleaning the external parts, the woman is placed in the knee-chest position and the urethra cocainized with cotton on an applicator. The gelatin is melted over a water-bath and the balloon rolled like a cigarette, gelatin being added until it resembles a suppository. It is introduced through a speculum into the bladder by a crane's-bill forceps and released. As distention progresses, pain and desire for urination come on. The rule is to leave the balloon in place for fifteen or twenty minutes. The pain is great in the first application, but the relief is equally so. In removing, the air is aspirated and the bag easily pulled out. The author has treated ten cases with success. The procedure is applicable only in subacute and chronic cystitis. Good illustrations accompany the article.

Treatment of Urethritis by Ichthyol and Blue Ointment. A.

T. ILINSKY (*Wratch*, Nos. 1, 2, 6, 1896).

The unsatisfactory results, coupled with undesirable and sometimes very severe complications, following a gonorrhea treated by injections of various drugs, and especially of silver nitrate, induced the author to employ the following method, with very good results, in fourteen acute, previously untreated cases, and in fifty-eight chronic cases unsuccessfully treated with different remedies.

The greatest possible rest, suspension of penis and testicles by means of a suitable bandage, with injections of ichthyol (one to two per cent, twice daily), will change the discharge, as to the amount and color, in four to six weeks, and sometimes stop it entirely. Chronic cases, with a slight or even profuse discharge, are generally improved by the following course of treatment:

1. All astringent or nitrate-of-silver injections are discontinued, using an injection of a pure adeps lanae emulsion (3 ij-3 viij) to calm the irritated surface of the urethra.

2. After several days an injection of two per cent. of ichthyol, gradually increased in strength, if necessary to six per cent., is used; the last injection produces pain, which passes away in fifteen to twenty

minutes without any other consequences. In some cases the discharge will reappear with the abandonment of injections. Here the microscope will reveal pus-cells, as a consequence of a subacute inflammation of the urethra. In such cases the use of the following ointment was of great service:

R Ung. ciner ʒ ss.
 Adipis Lanae, {
 Ung. paraffini, } aa 3 ij.

3. A soft bougie (No. 10-15) covered with this ointment is introduced every second day, and left in place for twenty-five to thirty minutes. The urethra bears the ointment very well, and satisfactory results are seen after fifteen *séances*. In cases of stricture, metallic bougies smeared with the same ointment are inserted. The bladder is washed with two-per-cent boric-acid solution when chronic urethritis is combined with pain in passing water. Ichthyol suppositories, eight centimeters in length (one grain in each), produce a striking effect. Visible improvement is seen in cases of prostatitis and other local urethral inflammations from the use of bougies of gray ointment.

[*Reviewer's Note.*—This method was used by me in two severe cases of gonorrheal complications with very good results. In one case, treated for years by different physicians, the endoscope revealed in the membranous portion of the urethra granulations, which discharged a thick, yellow pus. The patient, not tolerating applications of nitrate of silver, or any other caustic remedy, a bougie with the above-mentioned ointment was used for four weeks, with slight massage of the external membranous portion of the penis during the stay of the bougie in the urethra, with the result that the discharge stopped entirely, the endoscopic examination revealing a *restitutio ad integrum* of the urethral surface.

In the second case—prostatitis with chronic gonorrhea—the same method with massage from the rectum gave the patient relief after four sittings, the discharge and symptoms of prostatitis disappearing in four weeks.]

LAPOWSKI.

Extraperitoneal Rupture of the Bladder following Intravesical Irrigation. CH. AUDRY (*Ann. des mal. des org. génito-urin.*, 1896, p. 467, from *Arch. prov. de chir.*, March 1, 1896).

Five cases of this accident have been reported, four by Jeannel, one by the author. The patient was a man of forty, under treatment for gonorrheal cystitis. After irrigation with nitrate of silver, potassium permanganate by the Janet method was used. Two hundred and fifty cubic centimeters of a 1-to-3000 solution, at a pressure of one meter and a half, were injected into the bladder. The man complained of a sharp pain and inability to pass the solution, which was drawn by catheter. On the following morning symptoms of shock appeared, and forty grams only of urine could be drawn. A diagnosis of reflex anuria was made, but, on rise of temperature, Audry operated by median suprapubic incision, finding the space of Retzius infiltrated with urine—no peritonitis. The rupture was not sought, the wound drained, a catheter passed by the urethra, left in the bladder, and recovery followed.

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Original Communications.

CLINICAL AND PATHOLOGICAL OBSERVATIONS ON THE EFFECTS OF CASTRATION FOR PROSTATIC OVERGROWTH.¹

By J. P. BRYSON, M.D.,
St. Louis.

DURING the course of the discussion and experimentation having reference to the therapeutic value of castration for prostatic overgrowth, the collateral question has arisen whether the removal of one testis might not act as a prophylactic against the hypertrophy of the corresponding prostatic lobe. Within the past year opportunity has presented of making an observation bearing upon this point. The case, during the treatment of which this observation was made, was the twenty-eighth in my series of prostatectomies by the supra-pubic route.

CASE I.—*Prostatectomy on a Mon-Orchid.*—G. N. L., aet. eighty, was operated on July 13, 1895. At the age of thirty-nine he had an attack of mumps, during the course of which an orchitis developed, and completely destroyed the left testis. Only a small fibrous lump remained in an atrophied scrotal sac. The right testis was in fair state as to size and elasticity, and his sexual condition was quite good for one of his age. He had not noticed that the loss of the testis had affected this in any respect. The supra-pubic and perineal sections were done, and when the forefingers were made to meet in the prostatic urethra the left lobe was found to be larger

¹Read at the meeting of the American Association of Genito-Urinary Surgeons at Atlantic City, held in May 1896.

than its fellow. Both sides were deeply incised from above, and the prostatic capsule practically emptied—a veritable prostatectomy. The largest single mass of prostatic tissue was removed from the left side. This we are able to identify more certainly by reason of its having been the seat of a nest of three prostatic concretions, the bed of which they had eroded for themselves being visible.

The fact that the bulk of the lobe on the side corresponding to the atrophied testicle was distinctly larger than the other was easily demonstrated; but with the view of ascertaining whether the removal of a testicle at least ten years before any hypertrophic change might fairly be expected to begin had, in this instance, modified the histological elements to a perceptible extent. Specimens of the growth removed were submitted, along with other specimens made use of in this article, with a request for examination and report to Dr. William N. Beggs, a gentleman in whose competency and disinterestedness I had every confidence, and who was at that time instructor in pathological histology in the St. Louis Medical College. Following is his report:

“Section from *left* side of prostate. (Fig. 1, a.)¹ In this the glands form a very considerable proportion of the section, the lumina present considerable variations as to size and regularity, containing usually granular detritus, a few desquamated epithelial cells, and frequently one, or occasionally more, small concentrically laminated concretions. The epithelium consists of one or two layers of cells. In the smaller alveoli, in which there are usually two layers, the inner one is usually composed of distinctly columnar cells. In the larger alveoli the layer lining the lumen varies from tall columnar to cubical, and even somewhat flattened, cells. The cell bodies are usually of distinct contour, coarsely granular; sometimes they are goblet cells. The nuclei present the ordinary characteristics. The stroma is composed of bands of long smooth muscle fibers with typical elongated nuclei, with a slight admixture of connective tissue. Occasionally the stroma about an alveolus has a slight amount of infiltration with small round cells, chiefly mononuclear.

“Section from *right* side. (Fig. 1, b.) In this the alveoli are usually larger and distended by their contents, which usually consist of considerable quantities of mono and multi-nucleated (pus) cells, granular detritus, a few desquamated epithelial cells, and oc-

¹ These, and the other photomicrographs referred to in the text, were made for me by Dr. P. J. Heuer of St. Louis. The photographs are of sections made by Dr. Beggs.



FIG. 1, a.

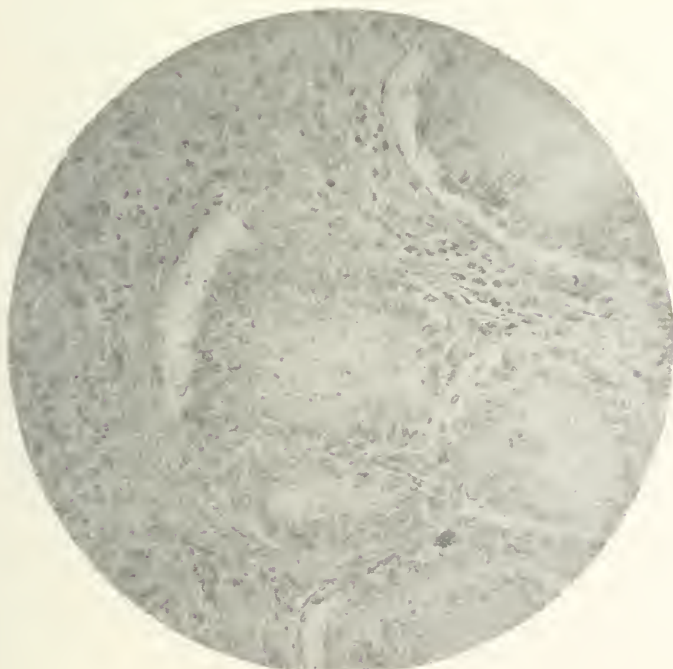


FIG. 1, b.

casionally a small laminated concretion. The epithelium is, in many alveoli, like that described in section from the left side, with a few leucocytes between the epithelial cells. In many, however, the epithelial cells have indistinct contours, are more granular, and the number of leucocytes greatly increased, sometimes so greatly as to cause distinct interruptions in the continuity of the epithelium. The stroma is densely infiltrated throughout most of its extent with small round cells, chiefly mononuclear, but with a considerable admixture of multinuclear cells. This infiltration is most marked immediately about the alveoli. The stroma itself consists of large, well formed, smooth muscle fibers of typical characteristics, and a slight amount of connective tissue arranged in interlacing or parallel bands. The spaces between them are filled and distended by the infiltrating cells. On the right side there is a suppurative inflammation of considerable intensity; on the left side there is a very slight commencing inflammation. There is no indication of retrogressive change due to other causes."

The suppurative changes referred to in the report were probably due to the long continued cystitis and the use of the catheter, aided by the concretions which seem to have blocked many of the ducts, as well as the alveoli. This tendency to the formation of concretions reached its climax in the development of a nest of calculi in the left lobe.

It seems clear then that the removal or destruction of one testicle as much as ten years before the hypertrophy should begin cannot be relied upon to prevent this change taking place on the corresponding side.

The question, however, which presses for solution is: What are the effects of castration on the hypertrophied prostate? The answer must surely come, not from the advocate, the critic, or the propagandist, but from the scientific field of direct observation. As a part, even though a small part, of the evidence upon which such a conclusion may be reached as shall enable the surgeon to use this means with satisfactory precision, the following observations are presented. The case is the thirtieth in my list of prostatectomies.

CASE II.—*Prostatectomy One Year After Castration*.—O. G., æt. sixty-four, had been brought to me by Dr. Bradberry of Maryville, Mo., early in April, 1895. The patient, a robust man, was then much depressed mentally by reason of the death within short intervals of several members of his family. The history was almost typically that of prostatic obstructive disease, and the examination

confirmed the diagnosis already made by Drs. Nash and Bradbury of Maryville.

The prostate, felt from the rectum, was well rounded backwards, and laterally, the left lobe being larger than the right. The interlobar groove was not distinguishable, and the forefinger barely reached the posterior border in the center, and failed to do so on either side. He had depended wholly on his catheter for eighteen months. The consistency of the lobes was equal throughout. They were plump, elastic, and painless. Cystoscopy revealed a bladder but slightly rugous, moderately injected about the trigone, pinkish salmon at base, and fundus without pockets and with a deep bas-fond. Sweeping the window from left to right the projection of the right lobe was seen to be less than the other. The left side presented a decided intra-vesical promontory, made up of two lobules. The instrument was cramped in the prostatic urethra. There was only a moderate degree of cystitis. Urinalysis and urinoscopy showing favorably, and the general condition being satisfactory, with the exception of a leaky mitral valve, which was well compensated, prostatectomy was advised, but declined, and he returned to his home April 25, 1895. He was castrated by Dr. G. N. Nash. He claims to have felt better on the sixth day. Continued to use catheter until the end of June, when he discovered there was only a small quantity of residual urine. Gradually he had regained power of voluntary urination, and was but little troubled at night. Bladder was being irrigated once daily, the use of catheter was now omitted, and he believed himself well. By December he had gained greatly in general health, and twenty-five pounds in weight, but the necessity to rise at night to urinate had gradually increased, and was then sometimes as often as thrice, and the urine had clouded again. January 20, 1896, after fatigue and exposure, he had complete retention, requiring relief by his physician, Dr. Gleves of Maitland. Since this he has been entirely dependent on the catheter. He was again brought to me on April 30, 1896, by Dr. Nash. The prostate, on examination, showed no appreciable change in size, shape, or consistency. No measurements were ever made of the length of the prostatic urethra. The urine had become decidedly purulent, contained triple phosphate crystals, some blood cells, and a few hyaline casts. The albumin had distinctly increased. Cystoscopy showed an inflamed bladder, in the walls of which the mouths of many small pockets could be distinguished. Lying in a deep depression behind the prostate, partly covered by thick tenacious muco-pus, was a small calculus. No change seemed to have taken place in the

prostatic projections, except they seemed redder, and the depression between the lobules springing from the left side had disappeared. May 1st, an attempt was made to crush the calculus. This failed because of its lying in such a deep pouch as to prevent its being seized by the lithotrite. On the next day epicystotomy was done, the calculus removed from a deep pocket, the lateral lobes incised from above, and 144 grains of prostatic tissue removed by the finger and rongeur forceps.

The projection from the left lobe was gnawed away with the forceps. The perineum was not opened, but the bladder was drained from above. Recovery was rapid and satisfactory. By the 20th the patient sat up for several hours, and, though the urine was still leaking through a small fistula, six ounces were drawn by catheter previous to irrigation. The patient now went about the hospital and out of doors for short walks. The supra-pubic fistula closed on the 22d, and, considering himself well, he began his preparations to return to his home. On the 26th, while walking about his room, he fell, and expired in a few moments. His young friend, a student of medicine, who was with him at the time, declared there was no sign to indicate the approaching end. The autopsy revealed disease of the mitral valve as the only assignable cause of death. The heart was probably somewhat dilated, the valve edges markedly thickened and rough. The kidneys were sound. There was a suppurative ureteritis on the left side, extending three inches from the bladder. The latter was nearly free of evidences of inflammation, its mucosa, about the base thrown into many folds, had scattered about the trigone some patches of extravasated blood, evidently undergoing absorption. The two incisions, one on either side of the prostatic urethra, through which the tissue had been removed at the operation, had healed satisfactorily, remaining only as narrow lines, a trifle redder than the adjacent membrane. A slightly irregular, broader line on the left side of the vesical outlet remained to show the site from which the projecting isthmus had been removed by the rongeur. I was hardly prepared to see so perfect a mucous lining to the bladder. The fistula above had entirely healed. The utriculus, remaining further down the urethra, had not been injured at all. I may repeat here that, using the same means of estimating in both instances, the last examination, made three days before operating, and one year *after* the castration, revealed to me no change in the size or consistency of the gland.

The second, and last, cystoscopy revealed greater evidences of obstruction in the way of pockets and inflammation than the first.

A secondary calculus had formed in the meantime. At the operation the bulk of the gland came fully up to my expectations.

These statements are, of course, made fully subject to the just criticism applicable to all mere estimates as distinguished from precise volumetric and gravimetric determinations. As a matter of fact, the discovery of so large a prostate on the second examination was a distinct surprise to me, having recently seen a case where the same methods of examination had shown a remarkable diminution in the size of the gland in a shorter interval after castration. A pre-

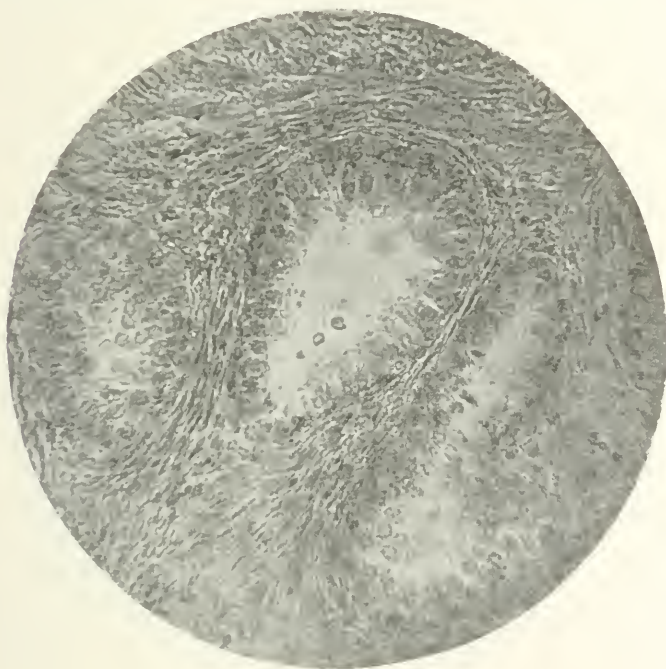


FIG. 2.

conceived bias would therefore have been in the direction of *under*, rather than *over*, estimation. Moreover, the 144 grains of prostatic tissue, washed free of blood and squeezed dry in a bit of gauze, should not be taken as adequately representing the amount removed in the operation. Some was lost by being washed away with the stream of hot water, and, owing to the conformation of the prostactome, all of the blood and much of the prostatic juices were squeezed from the masses as they were taken away from beneath the mucous membrane, bit by bit. Three hundred grains would more nearly represent the weight of the tissue removed.

In order to ascertain if the castration had produced any determinable histological changes in the gland quite fresh portions were submitted to Dr. Beggs, who reported, under date of May 21st, as follows:

Specimen from O. G. (Fig. 2.) "The glandular structures show but little change. The alveolar nature is shown by the moderately wide lumina, either empty or containing a slight amount of granular material and desquamated cells. The epithelium lining the alveoli varies in depth from two to several layers. The cell bodies are granular, and without well defined contours. The nuclei present

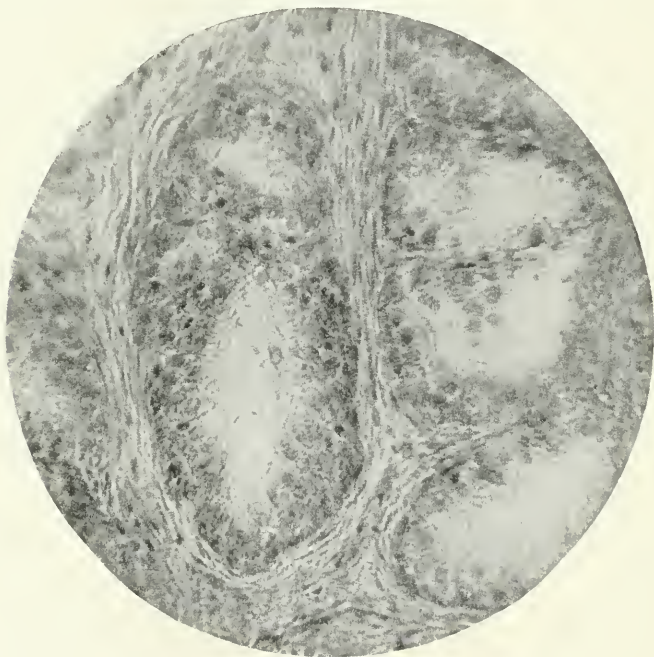


FIG. 3.

the normal characteristics. The septa between alveoli and lobules consist of broad bands of *large*, well formed characteristic smooth muscle fibers, with a slight admixture of connective tissue. There is no evidence of inflammation nor of any retrogressive change."

As affording the best means of comparison (though this is confessedly inadequate) I sent to Dr. Beggs with the other specimens some portions of the hypertrophied prostate of a man, aet. sixty, who declared himself sexually sound. His testicles were full and plump, spermatozoa were found in the urinary sediments before and

after prostatectomy, and he reported a nocturnal pollution during his convalescence. He was married to a wife several years younger than himself, and there was fair presumptive evidence in corroboration of his and her statements in the presence at his bedside of twin boys aged five. The report follows:

Specimen from E. (Fig. 3.) "In some parts the glandular structure forms the principal part, in others the muscular stroma. The alveoli vary considerably in size and regularity, and are either empty or contain granular material and a few desquamated cells. The epithelium varies in characteristics as in the preceding specimens. The stroma is composed of dense bundles of smooth muscle fibers and a little connective tissue. In a few places there is a considerable collection of mononuclear small round cells in the immediate neighborhood of the alveoli.

"In the specimens from the castrated individual there is no indication of any process *due to the castration.*"

209 N. Garrison avenue.

TWO CASES OF PROSTATIC HYPERTROPHY AFTER OPERATION—ONE BY VASECTOMY, THE OTHER BY CASTRATION.¹

By CHARLES H. CHETWOOD, M.D.,

Lecturer in Operative Surgery and in Genito-Urinary Diseases and Syphilis
at the New York Polyclinic.

THE two cases of prostatic hypertrophy which I have brought for exhibition this evening, one after ligation of the vas deferens or vasectomy, and the other castration, are important as cumulative material of these two operative procedures, which have excited more or less comment and investigation in this country and in Europe.

I have not prepared a paper upon the subject of prostatic hypertrophy, as the small amount of material which these two cases represent would hardly justify such an undertaking. I could not pretend to draw satisfactory conclusions from such a meagre showing, but I hope that by bringing up the subject before this Section, having previously notified several of the members of this and of the Surgical Section, to elicit a liberal amount of information on this interesting subject. I desire to approach the subject in a disinterested manner,

¹ Exhibited at the Genito-Urinary Section of the Academy of Medicine, January 12 1897. For reports of other cases by members of the section, see page 142.

and have operated in both cases without any preconceived opinion as to the ultimate result.

The first case is one of ligation of the vas deferens, whose history is as follows: W. M., æt. fifty-three; laborer. The patient had never had any treatment for his bladder until June, 1895, when he had his first attack of retention of urine, and a catheter was passed for the first time. Prior to this he had had a certain amount of frequency of urination night and day. He was treated at the Roosevelt Hospital, Out-door Department, by irrigations of the bladder at intervals of from one to three or four days for a period of about five months. At the end of this time his cystitis was somewhat improved, but the necessity of rising at night and the frequency of urination by day continued.

He had not been instructed in the habitual use of the catheter.

He entered the New York Polyclinic Hospital February 1, 1896, and was operated on by Dr. Dawbarn for fissure of the rectum. Following the operation his bladder trouble was somewhat aggravated and he was regularly catheterized; but as the instrument was passed by an attendant and was a metallic catheter, considerable irritation was produced, and on the third day after the operation the catheter was introduced with great difficulty, and was followed by more or less hemorrhage. From this time on the patient's bladder symptoms were persistently annoying, requiring the constant use of the catheter, which generally was accompanied by the passage of more or less blood.

On the 12th of February, through the courtesy of Dr. Dawbarn, I examined the patient and found per rectum a symmetrically enlarged prostate, about the size of a hen's egg. I found by the introduction of an instrument the indications of a more or less prominent third lobe, and I was anxious to test the value of ligation of the vas deferens, which, through the further courtesy of Dr. Dawbarn, I was permitted to do.

On the 13th of February, the patient having been properly prepared, I experienced little difficulty in finding the cord through an incision over the external ring, and after separating the vas deferens applied two ligatures and resected about $\frac{1}{4}$ inch of the canal between them.

For the succeeding ten days a record was kept of the amount of urine passed per catheter and voluntarily, the bladder being regularly irrigated whenever the catheter was passed. At first the amount of urine passed by catheter greatly exceeded that passed voluntarily, but toward the end of a week the amount passed voluntarily greatly

increased and that drawn by catheter diminished, so that when the patient was discharged from the hospital, February 24th, he could generally empty his bladder down to about four ounces.

I was able to keep the patient under my observation at his home. He was instructed how to irrigate his bladder and was furnished with a catheter, which he was told to pass before going to bed at night, and if necessary once during the day. So long as the patient continued this method of living he was able to keep himself comfortable and to go twelve hours without passing his water; but so soon as he became lax in the proper care of himself his old trouble would return with increased activity. The frequency and urgency of urination became very aggravating and the attacks of retention more frequent than ever before. At the present day, nearly one year since the operation was performed, I find his condition is really worse than it was one year previous, in that the difficulty of urination is much greater, the amount of residual urine has increased, and he is prone to frequent attacks of retention of urine which would cause him great distress were it not for his knowledge of the use of a catheter.

His prostate is the same size or larger.

In reviewing the history of this man's case, while it is not fair to generalize from a single instance, I am forced to believe that whatever relief he experienced was due to his introduction into catheter life.

In looking over the journals of Guyon of Paris, and Casper of Berlin, I find cases of vasectomy reported by Guyon, Cartier, Helferich, Legeu, Isnardi, and others, in most of which the conclusions reached seemed to be decidedly negative; and while there seem to be in some instances a certain amount of functional improvement, with one exception there was no decided diminution in the size of the prostate, and it was a question, where improvement was noted, whether or not it was due to the operation.

While I should hesitate to reach a conclusion from an experience based upon one case, I am frank to say that the impression received in the case reported was, that the patient had been introduced into catheter life and that when he properly employed his catheter and irrigation of the bladder he obtained a favorable condition, from which he quickly relapsed as soon as he neglected these regular means of treatment.

Case II was operated on by castration. Anton Salter, æt. eighty-one; a carpenter by trade. Gives a history of having had difficulty with his urinary function for the past eight or ten years, in the early

portion of which he had several attacks of retention, which were relieved by the passage of a catheter. During the past four years he has employed the catheter habitually, once before retiring at night, and again toward the early morning. He applied for treatment at the Polyclinic early in July last, at which time he passed his urine every hour by day, and, as already stated, the catheter twice at night. Occasionally his water would accumulate and refuse to flow during the day, when it became necessary for him to resort to his catheter for relief. He was treated by bladder irrigations several times a week, the passage of a full-sized steel sound and the internal use of salol and oil of gaultheria. His condition remained about the same.

On October 6th he enters the hospital for operation. The suggestion of double castration is accepted by him and prior to the operation a careful examination is made. It is found that he has four to six ounces residual urine; that the penil distance is about nine inches; that the prostate is fibrous and hard, and the upper portion can barely be touched with the end of the index finger, the distance being about three and one-half inches from below upward and about three inches laterally.

October 8th the operation of castration is performed. An incision is made over the external ring, the cord seized and drawn upon until the testicle is pulled from the scrotum, which is effected without difficulty. The cord is then ligated and the wound sutured. These steps are repeated on the opposite side. The advantages of this method of operating are the lesser liability of contamination from urine, the wound being high up, and the smaller amount of bleeding, there being one or two venous trunks instead of plexus of veins which exist in the scrotum. The recovery from the operation is uneventful. The catheter is passed at regular intervals. During the two weeks following the operation it is noted that any relaxation of the regular catheterization and bladder irrigation is followed by symptoms of bladder irritability, turbidity of the urine and tenesmus. This is relieved by systematic irrigation.

Two weeks after the operation another examination is made, the first after the operation. The prostate is found to be reduced fully one-third in size and is softer in consistency; the residual urine is reduced about one-third, and the penil distance is about half an inch shorter.

Three weeks after the operation the patient is discharged from the hospital and is allowed to return home without any instructions regarding the irrigation of his bladder or the use of a catheter.

Two weeks later he reports again, stating that his urine flows freely, and that he has given up the use of his catheter. The urine which he passes at this time, however, is quite turbid. He is again allowed to go without any instructions regarding the use of catheter or bladder irrigation.

He returns again in two weeks and reports that he has not been so well, having had to occasionally resort to the use of his catheter.

Early in December the bladder is irrigated at regular intervals, which has been continued until the present time. His present condition is that he passes his urine about every two hours by day. The amount of residual urine varies from one to four ounces. He passes the catheter once before retiring at night, by which means he is enabled to sleep without again rising. The urinary act is accompanied by no pain, and examination reveals that the prostate has been reduced fully one-half its original size and the penil distance from three-fourths to one inch less than its length before the operation was performed.

Regarding the subject of double castration, from the various cases which have been reported in the journals of Guyon of Paris, and Casper of Berlin, there seems to be little doubt that removal of the testicles does produce a certain amount of shrinkage in the prostate gland, but with a varying amount of subsidence of the functional disturbances. The operation itself I doubt will ever be a popular one, and it is difficult to determine just what class of cases it is most suitable for. It has been suggested that it might perhaps be most efficient in those cases where there seemed to be sexual irritability, and where the prostate was soft and succulent. My own case, however, was diametrically opposite to these conditions, the prostate being fibrous and hard, and the old man having practically given up any thought of his sexual function.

One of the principal arguments in favor of this operation as compared with prostatectomy has been its low grade of mortality. I believe, however, that the mortality is really higher than is credited to it. While castration in subjects with healthy bladders may be perfectly safe and unattended with danger, yet the danger is greatly increased where we have an advanced case of chronic cystitis, in which case the drainage of the bladder after the operation is hardly adequate.

A CASE OF ERYTHEMA SCARLATINIFORME.

By LOUIS J. FRANK, M.D.,
Milwaukee.

GEORGE B., a lad sixteen years of age, had not always enjoyed the best of health until he was taken from school, about a year previous to his illness. His family history shows that both of his parents have been subject to light forms of eczema; a cousin has died of tuberculosis at the age of twenty-six years. Had scarlet fever at the age of nine years, together with a younger sister, who died of this disease at the time. In June, 1892, after, as was assumed, he had exposed himself to the toxic action of *rhus toxicodendron* he was suddenly taken with a high fever (104°), lasting about four days, and accompanied by delirium. On the fourth day a rash appeared on the hands and the face, consisting of small and diffuse erythematous spots and vesicles. The eruption soon extended over the entire body, attended by considerable serous discharge, especially at the flexor surfaces and the genital regions. The itching was very severe until desquamation took place, which was very profuse. It appeared in the same order as the eruption in the form of thin, dry flakes on the body, and thick and extensive lamellæ from the hands and feet. The epidermis of the feet was the last to peel off. On the hairy parts of the body a pityriasis-like desquamation could be observed. The process of desquamation lasted about three weeks, at the end of which time the nails were beginning to be replaced by new ones, and the hair began to fall out. After this complete recovery took place.

A year and a half later, November, 1893, the patient was taken ill with tonsillitis and bronchial catarrh, accompanied by a feeling of malaise and slight raise of temperature. As all these symptoms began to subside suddenly an erythematous rash, consisting of small macules coalescing into larger hyperemic patches not elevated above the skin, appeared on the face and neck, accompanied by a prickling sensation of warmth and considerable itching. This process extended over the whole body in precisely the same manner as the first attack described. But this, and all the following *recidivæ* were marked by the absence of any serous oozing or discharge, the skin preserving a dry and parched appearance. After the desquamation was nearly completed in this attack a relapse took place, an intense erythema, starting at the angle of the mouth, spreading over

the face, especially the eyes and their neighborhood; likewise over the scalp. A condition of deep depression and exhaustion marked this stage of the disease, the pulse was low, and active stimulation had to be resorted to. This was followed by an extension of the erythema over the body and a complete desquamation.

The third recidiva took place, March, 1895, again, after lapse of eighteen months. It had the same characteristics as recidiva 2, both as regards its onset and further course. It was followed by a similar relapse.

In January, 1896, patient was taken ill with a tonsillitis, which ushered in the fourth recidiva. It was at this time that I saw him in consultation with Dr. Rogers, and the status present was as follows: The mucous membrane of the tongue, fauces, and pharynx showed evidence of catarrhal inflammation. The skin of the face, neck, upper part of the trunk, and the arms was deeply flushed, dry and hot, prickling and itching. The temperature was 103°; the pulse, 120. The lymphatic glands of the neck and head were enlarged and sensitive to touch. The urine in this and the previous recidivæ was free from albumen. This attack, like the previous ones, was followed by a relapse, more severe than the first, after the desquamation had been well nigh completed. To-day (after two months) the nails, dry and fissured, are being replaced by new ones, and the hair falls out considerably. His general health at present is excellent; indeed, it was noticed that after each invasion he grew apparently in size and increased in weight. The skin has now a perfectly healthy appearance, showing no trace of the desquamative process it has undergone.

In the year 1876 Besnier and Fèréal described an erythema ushered in by malaise and rigors more or less severe, scarlatina-like in appearance, usually spreading rapidly over the whole body within twenty-four hours, several days at the utmost, terminating in desquamation, distinguished by its dryness, abundant and extensive lamellæ, together with a tendency to recidivæ—as *erythème scarlatiniforme desquamatif récidivant*.

In searching through the literature of this subject I found a number of cases answering the description of this peculiar form of erythema.

CASE I.—Hallopeau and Besnier (French Society for Dermatology and Syphilography, 1895). The case in question underwent twenty relapses, was presented in the year 1876, and classified by one of the above authors as an erythema. Since then it has shown repeated attacks under the same form, usually without any definite exciting

cause—the last two attacks after mild doses of mercury, seeming to prove that agents of widely different nature may cause a vasomotor innervation leading to an erythema.

CASE II.—Loviat (*Jour. des Maladies Cutanées et Syph.*, 1894,) mentions the appearance of an erythema after convalescence from puerperal fever. A twenty-three year-old patient awoke suddenly at night with prickling over the entire body, nausea, and fever; next morning the color of the skin was deep scarlet. The erythema lasted four days, and disappeared after severe desquamation. There were after this repeated attacks without any assignable cause. L. assumes that the erythema was caused by the excretion of septic materials through the sensitive skin of the patient.

CASE III.—Under the title of a case of skin shedding, Dr. H. W. Blanc (*Jour. Cut. and Gen. Urinary Dis.*, Jan., 1893,) describes the course of an erythema in a twenty-year-old girl, occurring after a cold, accompanied by slight increase of temperature, nausea, vomiting, and headache; face swollen; on face, neck, upper half of chest, there appeared an erythema, gradually extending over entire body. After three days, active desquamation in large lamellæ. The nails were loosened, without, however, falling off, as had been the case in two previous attacks. Nine of her nearest relatives had been similarly affected. Blanc distinguishes it from scarlatina by its relapses, its non-contagiousness, low fever, and low pulse. The erythema soon disappears, the desquamation is severe. No albuminuria.

CASE IV.—In the April, '94, number of above journal Dr. Allen presents a case of erythema with several relapses. The diagnosis from eczema is easily made by the absence of itching, oozing, and the presence of distinctly marked desquamation. Each attack lasted ten days. No albuminuria.

CASE V.—Rotillon and Gougelet, in the *Ann. Derm. et de Syph.*, 1887, describe the appearance of an erythema in a twenty-seven-year-old lady following a psychical excitement, accompanied by cough and digestive disturbances. The face was edematous, likewise the extremities; the joints were painful. Albuminuria was absent. Patient had rheumatism three years ago. On the eighth day of the rheumatism a diffuse redness appeared on the trunk, which, after a week, extended over the extremities, followed by desquamation in large lamellæ. The patient has had four similar eruptions in the course of five years.

CASE VI.—In the *Arch. f. Dermat. and Syph.*, 1893, Ludwig Török, of Budapest, treats of a case of erythema occurring in a man fifty years of age, the affection beginning two to three days

after the patient had cut himself in the chin while shaving. After two more days the face became bright red. No itching or burning. The process extended to the body, accompanied by a profuse, flour-like desquamation. During the time of treatment the hair fell out, and the nails underwent a change. Recovery took place after four months.

CASE VII.—George Elliot (*Med. Record*, 1891,) speaks of a male who has had several attacks of erythema, especially of the hands and feet, accompanied by profuse desquamation. In May, 1886, the erythema spread over the entire body, accompanied by malaise and itching, especially of hands and feet. In May, 1887, one year later, only the hands and feet were involved. In May, 1888, a similar recidiva, with relapse in June. In February, 1890, and March, the attack was preceded by headache, costiveness, and chills. Before each attack there was a marked psychical excitement. There was at no time vesiculation or oozing, and the nails were never affected.

CASE VIII.—(*New York Med. Journal*, 1890.) George Elliot describes fully a case of this erythema occurring in a female, thirty-nine years of age, due to irregularities of menstruation, subinvolution of the uterus, and a prolapse of the left ovary. The eruption only occurred at the time of the menstrual period.

CASE IX.—Dr. Ohmann Dumesnil, at a meeting of the American Medical Association, held at Milwaukee, 1894, gave the clinical history of a case of erythema, which, however, to my knowledge, only affected the hands. He showed a most perfect specimen of the cast-off epidermis of the hand, similar in structure to that of the foot of the foot in my case. Several other cases have been reported, numbering about twenty in all.

Pathology.—Erythema scarlatiniforme desquamativa recidivans usually begins with fever of variable intensity, usually less than that of scarlatina. The erythema at first appears localized, and extends gradually soon after its appearance; from the second to the fourth day, desquamation is perceptible, which continues during the duration of the disease. Relapses are very frequent. This characteristic, its non-contagiousness, and absence of albuminuria, tend to distinguish it from scarlatina.

The pathology of this erythema is still an open question. We must either assume that the centers of the nerves of the vessels in the medulla oblongata and the spinal cord are affected by a chemical agent circulating in the blood, causing an active dilatation of the vessels of the skin, or that the foreign body within the blood forms chemical combinations within the organism, which produce a toxic

action in the circulation. In such manner only can the outbreak of drug erythemata, where an unusual quantity of the irritant substance may produce manifestations of long duration, be explained. In this class of irritating agents we must include decomposed bacterial products, especially ptomaines, active principles of irritant substances of yet unknown composition; as the possible etiological factor, I have cited rhus toxicodendron in my case. It is of not rare occurrence to find persons once poisoned by this herb, indicated by a vesicular, erysipelatoid eruption, to be again attacked by a similar lesion after the lapse of months, even years, without having again exposed themselves to its toxic influence. This fact seems to show that the poison during all this time has been stored away latent in the system, and that a depressed and debilitated physical condition, as produced by the occurrence of a catarrhal inflammation, angina, or bronchitis again brings the toxine into vitality and action. In the following manner alone we can at present explain the nature of relapses; firstly, that the poison has never been completely eliminated from the system, and remains latent; secondly, that such material changes have been effected in the structure of the tissues as to have reduced the organs to a *status minoris resistentiæ* in the form of adhesions, softening, swelling, and changes in the vessels and nerves, so that if the same or a similar irritating factor is brought to bear on the parts an identical recidiva is the result, generally beginning at the original starting point.

Etiology.—The etiology of this form of erythema is as obscure as that of all secondary erythemata. In the cases cited the apparent etiological factors are manifold, in one case being the toxic action of mercury, in another septic matter from a puerperal state, in a few cases psychological excitement, and in one irregularity of menstruation, complicated by a prolapsed ovary. It seems to be immaterial what form the indirect cause may take as long as it acts on a peculiarly impressionable nervous system, a characteristic known as idiosyncrasy.

The practical importance we derive from a close study of this peculiar disease is the differential diagnosis from scarlatina. We often hear of recurrent scarlet fever, which undoubtedly does occur, although I believe that many such cases may be classed under the erythema in question. I certainly doubt very much whether a scarlatina occurs in relapses from three to seventeen times, as I have seen reported.

Since the above article was written (March, 1896,) I am informed that three more attacks, similar to the one described by me, have

occurred at irregular intervals with the same symptoms and sequelæ. In conjunction with the above history I desire to mention a case which came under my observation lately, and which can safely be placed under the same category.

Wm. L., aged twenty-one years, took a severe cold in April, 1892, terminating in bronchitis, for the relief of which he took some quinin, the dose of which could not be determined. Within an hour afterwards an erythema began to appear on the hands, accompanied by swelling, heat, and sensitiveness; likewise on the upper and lower lips giving the appearance of an edematous, reddened ring surrounding the mouth. The hands continued to swell, until there formed exceedingly large bullæ on the back of the hands, filled with serous exudation. The genital region was affected in a similar manner, also the soles of the feet. After the inflammatory stage, which was attended by high fever, desquamation set in, the whole process lasting about two weeks. In November, 1894, two and one-half years later, a similar attack set in, terminating in the same manner, and followed by a recidiva a week later. The fourth attack occurred in November, 1896, beginning again with a severe cold. Quinin was again taken, and three hours afterwards the hands and feet, mouth, and genitalia, together with the lower limbs, became erythematous. The erythema on the lowerlimbs, however, was localized in patches of a dollar to a hand in size. These became edematous, and formed the basis of a large blister of the same size as the macule. The temperature for one week was at times as high as 105°. After severe desquamation of the parts affected complete recovery took place. The patches upon which the process took place were marked by pigmentation.

In connection with the above history of a desquamative inflammation of the skin I would like to refer to a debate of the New York Dermatological Society, reported in your JOURNAL of January, 1897, following the description of a somewhat similar case by Dr. Robinson. The eruption there described could be produced by the patient at will after the administration of ten grains of quinin.

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Netherlands Dermatological Society.

On the 25th of October, 1896, a dermatological society was founded in Holland, under the name of "Nederlandsche Vereeniging van Dermatologen." The officers elected were Dr. L. B. Selhorst (the Hague), president; Dr. Th. Braes van Dort (Rotterdam), vice-president; S. Mendes da Costa (Prinsengs 90, Amsterdam), secretary-treasurer.

Editorial.

THE DIAGNOSIS AND PROGNOSIS OF CHRONIC GONORRHEA.

THAT little dependence can be placed upon the mere cover-glass preparation of urethral threads, by staining and microscopic examination with its attendant time-consuming labor, because the absence of the gonococcus in those preparations examined does not justify us in pronouncing a case free, has been recognized now for a long time, and yet it is probably the only method pursued by a majority of physicians to-day to establish the fact of the presence or absence of this germ. Its absolute worthlessness was startlingly illustrated by Kopp¹ in a paper read by him, September, 1893, before an association of German scientists and physicians, in which he reported seven cases of young men with chronic trouble where he had pursued this method of examination alone, and after making in each case a series of from sixteen to twenty-five examinations and not finding the gonococcus, had allowed marriage. In all seven cases the wives, shortly after marriage, were found to be infected, gonococci being found in their secretions.

About this time Von Schlen² of Hanover, added to our methods of making examinations by describing his "third glass test" for obtaining secretions from the prostatic follicles. After the patient has held his urine for a sufficient length of time, three to four hours, he is to urinate into two glasses after the old method, and still to retain some urine in the bladder, then with the finger passed into the rectum, by pressure and massage of the prostate, its contents are pressed out into the urethra and the patient then urinates into a third glass. This method, in many instances, will afford a further collection of material for examination, and also suggests a method of treatment, which has been put into practice by many, namely massage of the prostate.

Independently and about this time, Dr. Fuller³ described his method of examination and treatment for seminal vesiculitis, show-

¹ Kopp, editorial in *Int. Journal of Surgery*, 1893, p. 307.

² Von Schlen, *Centralblatt für Krankheiten d. Harn- und Sexual-Org.*, 1893, Band iv, Heft 6-7.

³ Fuller, *JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES*, September, 1893 and 1894, p. 233.

ing the dependence, in many cases, of persistent urethral discharges upon this condition. There can be no question that many cases in which gonorrheal disease is supposed to have disappeared, may be found having a chronic inflammation of these organs, prostate, and seminal vesicles, or if not a chronic inflammation at least harboring pathological material. And yet the urine passed into two glasses as ordinarily done, will be found to be clear or will show a faint, floating mucous shred, which, when stained, will reveal only mucous, a few epithelial cells, and perhaps, here and there, a leucocyte, but no gonococci will be found after the most prolonged search. These cases nevertheless will be found to be thoroughly capable of transmitting the disease, and the fact perhaps will account for some cases of post-nuptial infection, where the husband was supposed to have been cured.

The question of the superiority of culture tests over microscopical examinations for the detection of the gonococcus may readily be admitted, but sufficient work has not yet been done along these lines to establish this superiority thoroughly. One of the most valuable contributions to this side of the question is that by Dr. Heiman,⁴ in which he gives the results of a series of examinations of chronic urethral threads by both the microscope and by culture tests in 61 cases. A glance at his tables, however, gives us a genuine surprise, that is, the very slight superiority which the examinations by means of culture experiments has over the examinations by means of the microscopè for the detection of this microorganism.

Out of 61 cases, gonococci were detected by means of the microscope in 13, while by means of culture media in only 14 cases was their presence established, so that unless the method of examination by cultivation can be proved to be easier, shorter, less tedious, and more certain, unless we can feel that we can rely upon it with greater confidence, but few will be tempted to add a culture plant to his ever increasing armament. In medico-legal cases, of course, the culture experiments could not be omitted.

Heiman gives some valuable hints in the methods employed for the collection of the materials to be examined. He had the patients urinate in small sterilized tubes which were placed in the centrifuge, thus quickly collecting all the material for examination. His work, however, is far from being finished; there are two portions at least of the genito-urinary tract on which some one must spend his time and patience, namely, culture experiments placed side by side with microscopical examinations of material obtained from the glands of

⁴ Heiman, *Medical Record*, December 19, 1896.

Littre and the pockets of Morgagni, and from the seminal vesicles. Then too, though Dr. Heiman, in his cases, includes examinations of material from the prostate, a perusal of his article would lead one to suppose that this was not certainly done in a thorough manner. He says that the prostate was pressed upon with the finger while the patient was urinating; it does not seem as if this would express the material sufficiently, in fact, it is not the best way to accomplish the purpose. The expression should be made while there is urine in the bladder, but not during urination.

The microscopic examination and detection of gonococci in material expressed from the glands of Littre and Morgagni, and from the prostatic follicles, separating this from that which comes readily from the urethra, has already been done in a series of cases by Pezzoli³ in Finger's clinic. The method of separation of material from different portions of the canal was ingenious, and of course requires patience and considerable training. First the anterior urethra was irrigated by means of a retrojection catheter with distilled water, the washings caught in glass vessel and labelled (*a*), material from anterior urethra. Then the patient lies on the table, and the largest size bougie à boule, capable of passing the meatus, is passed down to the bulb, with the penis laid over the pubes. One hand of the operator gently presses the organ, and the instrument is moved back and forth several times from bulb to meatus. The urethra is again irrigated with distilled water, the washings caught and labelled (*b*). These are the expressed contents of the urethral glands and pockets. Then the patient urinates into one glass labelled (*c*), this contains threads from the posterior urethra. Then if the urine be clear (*i.e.*, the urine still remaining in the bladder), the prostate is massaged and he urinates into a second glass labelled (*d*). This represents material from the prostate. If the urine is all cloudy, the bladder is emptied and then filled with a normal salt solution before the prostate is massaged.

The material in these four receptacles is collected by the centrifuge or by filtration. Pezzoli made all his examinations by the microscope alone, but he established the following points :

1. That the urethral glands and pockets in the acute stages of a gonorrhea are almost without exception affected.
2. That in cases of chronic anterior urethritis gonococci will be found more frequently in the glands of Littre and the pockets of Morgagni than in the anterior urethra itself.

³ Pezzoli, *Arch. Derm. u. Syph.*, 1896, pp. 39 and 183.

3. That in chronic posterior urethritis the prostatic follicles are also involved almost without exception.

It would seem as if a most valuable study could be made, after this manner, by placing culture experiments side by side with the microscopic findings.

In forming a final judgment as to the probable disappearance of gonococci, the value of an irritant injection of either silver nitrate or bichlorid of mercury solution must not be forgotten, but this can only be of value in the anterior urethra and its glands, for it is easily conceivable that gonococci in the recesses of the prostatic follicles or in the seminal vesicles need not necessarily be awakened by the traumatic anterior urethritis evoked by the irritant injection.

G. K. S.

Clinical Notes.

AN APPARENT EXCEPTION TO COLLES' LAW.

By C. TRAVIS DRENNEN, M.D.
Hot Springs, Arkansas.

COLLES' and Profeta's laws are too well known to the readers of this JOURNAL to require any explanation or particular mention concerning them. It pleases me to report the following case, believing that it may prove at least interesting if not instructive:

Mr. G., aged 51, was a syphilitic for seven years prior to his marriage with an apparently perfectly healthy young woman of 22. One year after marriage a little girl was born with well marked signs of hereditary syphilis; at the age of three this poor child became hemiplegic. From this attack she has never recovered. The father, a few weeks prior to the birth of this child, was much troubled with left hemicrania, particularly at night, and with pain from well developed nodes on the tibiæ of both legs. This pain was made to disappear under syphilitic treatment in about ten days or two weeks. Treatment was continued for about three months, when the patient becoming careless and indifferent it was given up; I would further add just here that this man had not prior to that time taken any medicine whatever for his trouble, only four bottles of "Sarsaparilla," as he states, leaving everything off after the chancre healed.

The second child was born two years after the first and as yet it has shown no signs of syphilitic disease, seemingly perfectly well

and always enjoying the very best of health. Two abortions occurred after this at the third and fifth month respectively.

Three years after the birth of the second child another child was born manifesting all the signs of hereditary syphilis, such as mucous patches about the mouth and anus, snuffles, characteristic eruptions, etc. This child died six weeks after its birth.

The mother at this time having heretofore remained apparently perfectly well showed signs of a well developed case of secondary syphilis and what seemed to be a typical and characteristic chancre of the left nipple. This poor woman has suffered terribly, both in body and mind and as yet is unacquainted with the real nature of the enemy which torments her. It is now six months or more since her first trouble began, and she has at times outbreaks of sore throat and mucous patches with quite perceptible enlargement of the inguinal, epitrochlear and cervical glands; in fact she seems to be going through a well developed stage of secondary syphilis.

Now the question naturally arises did this unfortunate woman become immunized through her first child, and if so did she lose that immunity whilst carrying her last, an unquestionably syphilitic child; again, should we question the paternity of the second child or should we rather attribute its good health to the slight and inefficient treatment administered to the father at or near the birth of the first child?

It is my belief that in this case we have an exception to Colles' Law; that the placenta in this woman acted not only as a filter to the germs themselves (if germs they be) but to the toxins as well, preventing them from entering the blood or having any influence upon this woman whatever. And again, I would not feel safe in questioning the paternity of the second child, but think it was begotten at a time when the syphilitic poison was inactive and rendered so through treatment which being insufficient permitted not only a breaking down of the father's general health and partial paralysis of the right side one year ago, but the sad and disastrous results which we have detailed above.

ERYTHEMA MULTIFORME—REPORT OF CASE FOLLOWING CIRCUMCISION.

R. W. KNOX, M.D.,
Houston, Texas.

THIS form of erythema is rare, on that account easily overlooked, and sometimes mistaken for more serious trouble. In my own practise only two cases can now be recalled, and these have occurred since I have begun to interest myself in the study of dermatology. The first of these was associated with an attack of acute gonorrhea, and the last followed an operation for circumcision in a young boy. It appeared singular that these two cases should have had a somewhat similar origin, yet, by reference to the literature of this subject such cases are not unusual.

Operations upon the urethral tract, such as the introduction of a steel sound, genito-urinary disorders of various kinds, operations upon the uterus, etc., have been known to cause an attack. While these facts have been noted in connection with the disease, other and widely varying causes have been given. Violent emotional paroxysms have been known to precede an outbreak. Others have noticed it in epidemic form, and it has been seen as a complication of icterus, cirrhosis of the liver, and catarrh of the stomach. It has been noticed as a forerunner of an attack of cholera.

The etiology is obscure. Lewyn concluded that the cause was a reflex action by irritation of the genito-urinary apparatus, but Van Harlingen, in his very excellent article on this subject in the Reference Hand-book of the Medical Sciences, thinks this view too narrow to cover all cases. Luzzato has found isolated and grouped cocci in the blood of erythematous patients.

The disease seems to be closely identified with urticaria in that it is of nervous origin. The irritation, whether coming in the form of shock or violent emotional paroxysms through the central nervous system, or acting from the peripheral surfaces, the same effect is produced; *viz.*, a dilation of the capillaries of the corium, and an exudation therefrom. The irritation is transmitted in a reflex manner by a sensory nerve through the sympathetic ganglia, in fact, both the cerebro-spinal and sympathetic systems take part in the process. It is reasonable to believe the impression is conveyed through the sympathetic system, on account of the tardiness of the eruption in making its appearance after the original irritation has been pro-

duced. When the eruption appears upon the skin after an operation on the genitalia, or from other causes, the interval between the two may be from twenty-four to thirty-six hours. The treatment is empirical, and called for only as the general symptoms of the patient would indicate.

The following case has several points of interest: B. C., a bright boy of five years, who presented a good family history, and had never had any serious illness, was brought to me for treatment. The trouble was a nervous one; appetite poor, color pale, and occasionally a little fever. At night was restless and would cry out and groan in his sleep, and often remain awake for several hours. Occasionally there was some complaint of pains in the legs and lower part of the abdomen. During the day he would play as usual without complaint. On examining the penis I found a tight foreskin, closely adherent to the glans. The operation of circumcision was proposed and readily agreed to by the parents. Chloroform anesthesia used, and the operation begun after the corneal reflex had disappeared. The mucous surfaces were rather tightly adherent, and their separation was attended with considerable reflex muscular action, notwithstanding a liberal quantity of chloroform had been administered; in fact, quite as much as was considered safe. The patient's first night after the operation was his best for many a week. On the second day a faint pinkish rash made its appearance over the greater portion of the body, attended with itching, burning, and some fever. At the same time fine papules were noticed covering the extensor surfaces of the arms and legs. This eruption was unlike the ordinary flattened papules seen in erythema at this location, but resembled more a cutis anserina or lichen pilaris. About three days after the operation spots of a brownish-red color, slightly raised and varying in size from a split pea to a silver dollar, made their appearance in the region of the buttock, thighs, and small of back. The temperature varied at different times of the day, the highest point 104° F. Some irritation and pain were complained of; in fact, the patient was generally miserable. The youth of my subject was a drawback in the way of gaining information regarding subjective symptoms. The swelling of the penis increased considerably, and upon the mucous surface of the glans a grayish looking superficial ulceration formed, with considerable secretion. This secretion caused any dressing that could be placed over the glans to adhere with tenacity. After the eruption had lasted several days a crop of large vesicles or bullæ made their appearance, seated upon the larger erythematous lesions, situated upon the buttocks and small of back. The eruption took no other

shape than the one given: *i. e.*, a general erythema, covering nearly the entire surface, disappearing and returning at irregular intervals. This redness was followed by fine papules covering the extensor surfaces, principally the feet and legs, hands and forearms. This was in turn followed by inflammatory spots of various sizes, the larger of these spots subsequently developing a number of large vesicles. The eruption upon the body and penis with its high temperature, complicated an otherwise simple operation, and was more annoying in a child than it would have been in an adult. The eruption lasted about ten days, leaving no pigmentation, and only slight desquamation. From this time the child made an uneventful recovery, and was entirely relieved of its former nervousness, and general health was much better than before the operation.

It may be well to state that my patient was the subject of occasional attacks of urticaria before the operation, but none has been noticed since, although but three months have elapsed since the latter was performed. This case would seem to add weight to the fact generally admitted that urticaria and erythema multiforme are closely related, both being of a reflex nature and occurring in patients of a neurotic tendency.

Book Review.

A Pictorial Atlas of Skin Diseases and Syphilitic Affections. In Photolithochromes from Models in the Museum of the Saint Louis Hospital, Paris. With Explanatory Wood Cuts and Text. By ERNEST BESNIER, A. FOURNIER, TENNESON, HALLOPEAU, DU CASTEL, HENRI FEULARD, and LEON JACQUET. Edited and Annotated by J. J. PRINGLE, M.B., F.R.C.P. Paris: Rueff & Co.; London: F. J. Rebman; Philadelphia: W. B. Saunders. Parts I. to VI.

The first six parts of this atlas have been published, and an accurate conception may be formed of a work which will be the most artistic and valuable addition to clinical dermatology.

The museum of the Saint Louis Hospital, in Paris, is known to all workers in this department of general medicine, and, although it is scarcely thirty years since the collection was begun, it now numbers nearly two thousand models, whose perfection in design and coloring are the admiration of all who have been fortunate enough to see and study these exquisite examples of M. Baretta's skill.

The difficulties which attend the reproduction of color work by lithography and allied processes are known to all who have had experience in such matters; the admirable manner in which the color

effect and drawing of the models has been accomplished in the numbers of the atlas already published will be best appreciated by those who have seen the original preparations. While necessarily lacking in the feature of relief, which adds so much to the value of a model, in all other details the lithochromes are most accurate and beautiful reproductions of the diseases originally portrayed, and are certainly superior to most of the work found in similar atlases.

This collection of plates is intended to represent typical examples of the more common skin and syphilitic eruptions, and it will supplement in an admirable manner the international work on rare skin diseases now in course of publication. A sufficient number of unusual conditions are, however, portrayed to render the work instructive to the specialist as well as to the general practitioner.

Each colored illustration is accompanied by a descriptive text furnished by the physician under whose direction the model was made. The text is furthermore illustrated by explanatory woodcuts and other illustrations, which add to its clearness.

Although not intended as a full *exposé* of our knowledge of the diseases in question, many instructive points in differential diagnosis and treatment are considered in so far as they pertain to the case portrayed.

The views of our French *confrères* regarding certain disputed questions in dermatology, as the relationship of lupus erythematosus to the tuberculous process, while not generally accepted, are instructive, and supported by numerous clinical observations.

The plates representing dermatitis herpetiformis, syphilitic chancres in women, lupus erythematosus of the face, tertiary syphilis of the tongue, and disseminated epithelioma of the face are worthy of special mention, though it is difficult to designate such where the excellence of all is so apparent.

The English editor, Dr. Pringle, has added much to the value of the work by his careful supervision of the translation, as well by his critical notes and references to other publications.

J. A. F.

Society Transactions.

THE THIRD INTERNATIONAL CONGRESS OF DERMATOLOGY AND SYPHILOGRAPHY.

(Continued from page 80.)

SPECIAL COMMUNICATIONS.

Ringworm* and the Trichophytos.

DR. SABOURAUD (Paris) in opening the discussion gave the results of his most recent researches. He divided the fungi into two classes, the Tricophyta proper and the Microsporon Audouini, which, he holds, is a totally different species.

I. The Tricophyta have these peculiarities:

(1) They produce upon the skin of the human body circinate lesions.

(2) In these lesions only two forms of mycoid development are seen, (a) the mycelial filament and (b), the endospore or mycelial spore.

(3) External sporulation does not occur in the skin lesions.

(4) It does occur, however, in culture, and here bunches of external spores are formed, sporotrichum of Link and Saccardo.

(5) They grow readily at low temperatures (15° – 20° C).

(6) Growing on culture media, they assimilate considerable quantities of hydrocarbons, sugars particularly.

There are several species in this class of fungi found on the human skin and exhibiting these characters. The class is the Sporotrichum. It seems probable from recorded observations that the species have distinct geographical limitations. The author then reviewed the three varieties more prominent in his researches.

(1) *Tricophyton Endothrix*.—This variety is seen usually in children, producing small, scaly lesions of the scalp and of the skin over adjacent parts. It numbers 1,000 to 2,000 Parisian children among its victims annually, but is apparently not of the same importance in England, Italy or Germany.

(2) *Tricophyton Ectothrix*.—Differing from the endothrix this species does not invade the hair, merely surrounding it with a sheath of mycelium. It is the tricophyton of the adult and is comparatively rare. All tricophyta of the adult are of animal origin by direct or indirect contagion and in consequence are separate and distinct from the endothrix of almost exclusively human development.

(3) *Tricophyton Endo-ectothrix*.—As its name implies, this fungus is found both inside and around the hair. This form is also of animal origin and quite common in France. Whatever the form of the fungus on the animal, when transplanted to the human subject it takes the form of the ecto, or endo-ectothrix. The cultural and mycological characters of these species were discussed, together with their pleomorphism and the reasons for differentiation founded on them elucidated. (A digest by Sabouraud appears in the November number (1896) of the *Annales de Derm. et de Syph.*)

II. Sabouraud considers the *Microsporon Audouini* originally described by Gruby (1843) as the only example so far discovered of the second class of fungi. It is especially common in France and England, causing an equal or greater number of cases of disease than all the tricophyta. It is rare in Italy, Germany and Hungary. Its distinguishing feature is the fact that it is the only fungus capable of passing through a developmental cycle with sporulation on the human body. In this peculiarity is found the reason for its extreme contagiousness and difficulty of cure. The mycelia are usually found in the hair shaft, the ecto-spores surrounding it. The author then drew attention to cases of ring worm in which the fungus resembled neither tricophyton nor microsporon, but approached more closely the achorion of favus.

DR. ROSENBACH (Göttingen) confirmed by his observations the

doctrine of the plurality of fungi in ringworm. He thinks the tri-cophyton has pus-producing power and that it is not necessary to call into question the pyogenic cocci.

MR. MALCOLM MORRIS accepted plurality of fungi as a fact, but objected to Dr. Sabouraud's distinction between ectothrix and endothrix which he regarded as largely accidental. The small spore variety is the one most contagious and difficult of cure. Each type of the disease, however, need not have a particular causative fungus.

Alopecia Areata.

DR. SABOURAUD gave the results of his researches which have been reviewed by Dr. Brocq in these pages (Sept. 1896).

DR. BLASCHKO (Berlin) pointed out three facts which militate in favor of the infectious nature of alopecia areata. (1) The erythematous tint of recent patches; (2) tumefaction of occipital lymph nodules, which often accompanies the beginning of the disease; (3) the fact of experimental contagion. He related an instance of the last in a man who rubbed scales from a recent lesion into his forearm. Three weeks later there appeared at this point a typical area which was cured at the end of two months in the usual fashion.

Eczema Seborrhoeicum. Its Contagiousness and Transmissibility in the Inguinal Regions.

DR. PERRIN (Marseilles) reported five cases. The eczema was developed primarily in these regions; it had not been preceded by pityriasis capitis or other local lesion. All the cases occurred in young married people, in two of whom the disease developed about a month after cohabitation. The facts were carefully sifted and it seems difficult to deny the author's conclusion of transmissibility.

Microbes of Seborrhœa.

DR. VAN HOORN (Amsterdam) found constantly three forms of microbes: (1) large spherical bodies with double contoured membrane and granular contents, (2) smaller oval bodies, (3) a very small bacillus only recognizable with high magnification. The first two have been described by Malassez, Bizzozzero and Unna; the last by Unna alone. By culture they were separated. The spherical bodies are a species of saccharomyces. The oval bodies are identical with Unna's flask-bacillus. Of this Van Hoorn obtained numerous generations. He claimed that the three forms occur constantly in the scales of seborrhea.

Fatty Sudoriparous Cysts.

DUBREUILH and AUCHÉ (Bordeaux).—There is no mention in literature of cysts of the coiled portions of the sweat glands. The authors' observation shows that such cysts do develop containing almost pure fat, adducing further evidence in favor of Unna's assertion regarding fat production here. The patient, aged 77, suffered from almost absolute anidrosis from infancy, although sweating

could be produced by pilocarpin. His skin was brownish, scaly and simulated ichthyosis with seborrhea of the scalp and seborrheal warts on the body. The tumors were scattered everywhere but particularly over the limbs and buttocks. They were rounded, hard, pea-sized, lying under the skin and more or less adherent to it. Some, more superficial, were soft and fluctuating. On puncture, fatty material escaped, soft, semi-liquid and resembling oil. On the buttocks the tumors were coherent and formed plaques.

Histologically, the cysts showed thin walls lined with epithelium consisting of two or three layers of flattened cells, not cornified and very different from those lining follicular cysts. There were found dilated glomeruli also, representing all intermediate stages from the normal to complete cystic cavities formed by fusion of all the coils of a glomerulus.

(To be continued.)

NEW YORK DERMATOLOGICAL SOCIETY.

TWO HUNDRED AND FIFTY-SIXTH REGULAR MEETING, HELD ON
TUESDAY EVENING, NOVEMBER 24, 1896.

DR. J. A. FORDYCE, *President, in the Chair.*

A Case for Diagnosis.—Presented by DR. FORDYCE.

The patient was a woman, fifty years old; a widow. She had been married twenty-five years, during which time she had had six children and one miscarriage; five of her children are living and well. Eleven years ago she had a paralytic stroke affecting the right side and followed by a loss of speech which persisted for two weeks.

At the present time she has a symmetrical erythema of the cheeks and nose of a purplish-red color, with slightly elevated and well defined edges; on the right cheek there is considerable atrophy of the skin, while on the opposite side there are several retracted scars. On the right side also a subcutaneous nodule can be made out. The left ala nasi is partly destroyed from an old ulceration. There is considerable induration underneath the erythematous lesions, but no scaling or separate nodules suggesting lupus vulgaris. Her right ring-finger is swollen from involvement of one of the phalangeal bones.

Dr. Fordyce said he presented the case for diagnosis. He was at first inclined to think that the woman had had syphilis, upon which a lupus erythematosus had become engrafted. Large doses of potassium iodid had failed to produce any effect upon the induration or the bone lesion. The lesions on the cheeks had existed about eight years.

DR. C. W. ALLEN said he could not make a positive diagnosis. He would, however, make a provisional diagnosis of syphilis, and he thought that disease should not be excluded until after extraordinary methods of treatment had been employed and had failed. In a case

of this character he would not be satisfied with the ordinary methods of treatment.

DR. E. B. BRONSON said he did not think that the lesions on the face were due to either syphilis or lupus. He did not care to venture a diagnosis.

DR. G. T. JACKSON said he did not regard the case as one of lupus erythematosus. He would be inclined to try syphilitic treatment. He had had one case of lupus vulgaris in which there were nodules deep in the skin, as in this case.

DR. S. SHERWELL said he thought the lesion on the right cheek simulated lupus erythematosus. He was inclined to agree with Dr. Fordyce that the case was one of syphilis upon which a lupus had developed.

DR. LUSTGARTEN said he was inclined to look upon the process as a lupus vulgaris. The woman stated that she had had some nasal trouble, which was operated on, and it is possible that the infection of the cheeks was from that source. There is apparently at present some infiltration of the left wing of the nose, which is fairly characteristic of soft, granulomatous lupoid tissue. The swelling of the finger he was inclined to look upon as a tubercular osteomyelitic trouble. In the lesions on the face he saw no evidence of lupus erythematosus, and the process had existed too long for syphilis (eight years). He would make a diagnosis of lupus vulgaris of the superficial, macular type, with some unusual features.

DR. FORDYCE, in closing the discussion, said he had had the patient on increasing doses of potassium iodide for several weeks, without producing any effect on the local process. He was inclined to agree in part with Dr. Lustgarten, that the original lesion on the cheek was a tubercular gumma which had healed, leaving a retracted scar, and that the other process was secondary. It was, in his opinion, lupus erythematosus secondary to a tubercular process.

A Case of Lupus Erythematosus Changing into Lupus Vulgaris.—Presented by DR. GEORGE T. JACKSON.

The patient was a male, aged 18 years, who gave a history of having had skin lesions on the face for the past eight years. He was first seen by Dr. Jackson four years ago, when he presented himself at the clinic at the Woman's Medical College of the N. Y. Infirmary. At that time he had about twenty small and large red, scaly patches, round in shape and slightly depressed and cicatricial. The lobes of the ears were similarly affected, especially that of the right ear. There was an entire absence of tubercles in the patches. The glands on both sides of the neck were enlarged, and one on the right side had suppurated. A diagnosis of lupus erythematosus was made.

In February, 1894, the boy was sent to the Presbyterian Hospital on account of the enormous enlargement of the glands, which were removed by Dr. McCosh. No sooner had the boy recovered from the effects of the operation than it was noticed that the patches on the face began to pale. On April 28th, which was just after his discharge from the hospital, all the patches had cleared away excepting one or two very small ones on the face and those on the lobes of the

ears. The removed glands were found to be tubercular. His face remained quite well for six or eight months, when new spots appeared, and in March, 1896, he presented himself again with a number of small patches on the face showing lupus tubercles; both ears were swollen, slightly red and studded with small brownish nodules which were soft when pressed against with a coarse needle. The patches on the face have done well under a 25 per cent. salicylic acid—creosote plaster.

The speaker said it appeared to him that this case well illustrated the ideas of some of the French authorities that lupus erythematosus may in some cases be due to a toxin developed in a tubercular deposit at some distant point. In this case it would seem that the sequence of events was as follows: 1st: enlargement of the cervical glands from tubercular infection; 2d: the development of lupus erythematosus as the result of toxic infection; 3d: the development of lupus vulgaris as the result of infection by tubercle bacilli.

DRS. CUTLER AND KLOTZ agreed with Dr. Jackson that the case was one of lupus vulgaris.

DR. ALLEN said there was a suspicion in his mind that the original process may have been one of lupus vulgaris simulating lupus erythematosus; however, as Dr. Jackson had observed the case for so long a time, that would hardly be possible. The case certainly illustrated a very interesting sequence of events.

DR. LUSTGARTEN said we had the statement of Dr. Jackson that the patient formerly showed symptoms of lupus erythematosus. He did not see any at present. The scaliness of some of the lesions might simulate such a process, but there are some cases of lupus vulgaris which very closely resemble lupus erythematosus. He regarded the case as one of lupus infiltration secondary to tubercular glands.

DR. JACKSON, in closing the discussion, said the large glands in the neck had attracted his attention from the very beginning, and he wondered whether it was not one of those cases which the French have mentioned of lupus vulgaris simulating lupus-erythematosus. After the removal of the glands the tubercles on the ears appeared.

A Case of Multiple Epithelioma.—Presented by DR. C. W. ALLEN.

The case was one of multiple epithelioma of the face in an old man who had the horny form of seborrhea with warty-like growth on various parts of the face. Four months ago he first noticed a lesion on the left side of his nose, which developed into a typical epitheliomatous ulcer. Later a second one appeared near the left ear and a third one on the opposite cheek. Under applications of a 25 per cent. pyrogallol ointment the lesion near the ear has entirely healed, and Dr. Allen said he expected to present the man at a future meeting so as to show the result of this treatment upon the large ulcer on the nose, which he expected to cure.

DR. SHERWELL referred to a paper read by him ten years ago, in which he spoke of the frequency with which moles on the face degenerate, as compared with those on other parts of the body. As

regards these seborrheal warts, the speaker said he recently had a case which he treated in a very simple manner and with very satisfactory results. The patient was a man over ninety years of age, whose face was covered with seborrhœic verrucæ which greatly distressed him, and which were in danger of developing into epitheliomata. He had been treated for two or three years by one of the members of the Society without much effect. Dr. Sherwell prescribed white precipitate ointment, 10 grains to the ounce, and under applications of this, alternated with a weak resorcin and salicylic acid ointment, the verrucæ entirely disappeared and the man now has a face like a baby.

In the treatment of epitheliomatous lesions like the one shown by Dr. Allen, the speaker said he preferred to employ the acid nitrate of mercury as an escharotic, first having used curette if necessary, allowing it to remain on for the time judged proper and then neutralizing it.

DR. G. T. JACKSON said that for the ordinary flat warts, he preferred to use salicylic acid rather than pyrogallol. He applies the former in the form of plaster muslins. He was inclined to doubt that the lesion on the nose in Dr. Allen's case could be cured with pyrogallol alone, without previous curetting.

DR. DANIEL LEWIS inquired of what use pyrogallol could be after such a lesion is thoroughly curetted?

DR. JACKSON replied that such an application would be apt to destroy any small foci of diseased tissue, that might have been left behind.

DR. A. R. ROBINSON said he would not think of treating such an ulcer with pyrogallol, with or without previous curetting. In such a case he would rely on nothing else than arsenious acid paste. It should be used in the proper strength, according to the vulnerability of the parts. In Dr. Allen's case he would apply a paste composed of equal parts of arsenious acid and gum acacia and allow it to remain on probably for from thirteen to sixteen hours. This should set up an acute dermatitis, which will kill all the diseased tissue. One application should be sufficient.

The speaker said he had employed pyrogallol a good deal, and it had never given him satisfaction. It causes a limited amount of necrosis and that is all. The lesion on the cheek in Dr. Allen's patient led him to speak of a form of cancer which in the beginning closely resembles an ordinary catarrhal dermatitis; it is like an eczema and looks easy to cure, but a microscopical examination will show that pathological changes have occurred deep down, as far perhaps as the coil of sweat glands, with little or no change in the epithelium; the latter changes may not occur until the lesion has existed several weeks or months. In treating such a case it is necessary to employ an agent which is powerful enough to effect the deeper structures as well as the epidermis. For this purpose, he knew of nothing better than arsenious acid, unless one preferred to use the knife. In either case we should get well beyond the actual limits of the diseased area, in order to avoid a recurrence.

His own studies lead him to believe that under the head of cancer more than one disease is included both as regards etiology and pathology.

DR. H. G. PIFFARD said he agreed substantially with Dr. Robinson regarding the value of pyrogallie acid. He discarded it after employing it in a few cases with no resulting benefit. He did not think that a lesion like the one on the nose in Dr. Allen's patient could be entirely cured by the curette, unless some application, such as the chloride of zinc, were employed afterwards. The arsenious acid paste would be vastly more reliable than the curette and the zinc, although vastly more painful.

DR. S. LUSTGARTEN said that pyrogallie acid had not accomplished all it originally promised to do in the treatment of epithelioma. Even in Vienna, where it was first employed, it is no longer used as a regular treatment. From applications of arsenious paste he had observed excellent results. The danger of arsenic intoxication should be borne in mind if the paste is used over a large surface. The treatment he usually employs is to scrape out the lesion and then apply the caustic potash stick very energetically. This was the favorite treatment of Billroth where there was no indication for surgery.

DR. ROBINSON inquired whether Dr. Lustgarten had ever seen a case of arsenic poisoning following the use of the paste as strong as used by Marsden? He has employed it over large areas without any bad effects.

DR. LUSTGARTEN said the arsenical paste to which he had referred Pasta Cosini, contained one part of arsenious acid, three parts of cinnabar and twenty-four parts of fat. It was never applied to an area larger than half of a square inch. A case is on record where Hebra's paste, which contained opium, and which was painless, caused death from arsenic intoxication. He inquired whether the arsenious acid could not be combined with cocaine?

DR. ROBINSON said that the addition of cocaine to the paste has no effect on the pain.

DR. PIFFARD said there is less danger of intoxication with the the stronger arsenious acid preparation than with the weaker. Where it is used in the strength of 1 to 24 or 25 it would be dangerous, but when equal parts are used there is hardly any danger of absorption.

DR. LUSTGARTEN said this would indicate that the stronger preparations are not so deep in their effects. They probably produce an eschar which prevents the absorption of the arsenic.

DR. DANIEL LEWIS said that numerous trials have convinced him that pyrogallie acid is not a caustic; furthermore, he considered it a dangerous application, in that it stimulates infiltration and does not destroy diseased tissue. He stopped using it years ago. The speaker said he had learned from experience never to apply Marsden's paste or any similar preparation without having the patient under very close observation. In one case the effect of the applica-

tion may be much more pronounced in a few hours than it is in a couple of days in another case.

DR. ALLEN said that in selecting a method of procedure in these cases we must consider the site of the lesion, the age of the patient and the possibility of producing an auto-infection if we resort to surgical measures or curetting. Cancer is looked upon as one of the auto-inoculable diseases, and if we use the curette and open the vessels we expose the patient to just such a course of events as occurred in Dr. Jackson's case after the removal of the tubercular glands in the neck. The speaker said he had observed very good results from the use of arsenious acid paste, but one objection to it is the severe pain to which it gives rise. Pyrogallic acid is scarcely painful at all—at least, patients do not complain of it very much—and he had seen some good results from it. Lately he had not employed pyrogallic acid in epithelioma as much as formerly, but in this particular case there seemed to be a good chance of its exerting a favorable action, and it surely had effected a cure in the lesion in front of the ear so far as present appearances go. Whether the cure would be permanent or not he could not say. He intended to continue his present method of treating the lesion on the nose, although if it showed any signs of spreading he would substitute the arsenical paste.

DR. H. G. PIFFARD said he did not think Dr. Allen's patient would be cured, no matter what method of treatment he adopted. The speaker referred to the internal use of red clover tops (*trifolium pratense*), which are known to have a remarkable influence on cancerous growths, although not always a good one. There is a temporary improvement, followed by a relapse and the patient is worse off than before; at least, that was his experience in a number of cases treated by this method at the Charity Hospital about fifteen years ago. The patients were instructed to go out into the field and eat three clover blossoms three times daily, and then increase the number until they took nine three times daily. At first there was a rapid improvement, but soon their condition became aggravated, and the treatment was discontinued. An extract of clover tops made in Chicago was also employed with a similar result. Afterwards, Parke, Davis & Co. put a similar preparation on the market. These flowers certainly have a very decided effect on malignant lesions, and if the proper dose could be ascertained their use might be followed by beneficial rather than injurious results.

DR. FORDYCE said that many years ago he saw a man with a lesion on the face, probably an epithelioma. He was given anti-syphilitic treatment without any effect. The lesion was also operated on twice, but each time it recurred. He then took one pound of Parke, Davis & Co.'s preparation of clover tops and the lesion disappeared.

DR. LUSTGARTEN said that the good effects produced on these growths by certain internal remedies seems to be due to a local inflammation like tuberculin, etc., very probably the result of some irritating principle; the effect is usually temporary.

DR. ALLEN said that the addition of cocaine to these pastes seemed to have absolutely no effect on the pain. Several years ago Dr. Lewis recommended a preparation consisting of caustic potash, vaseline and cocaine. Dr. Allen said he had had difficulty in compounding this preparation; the cocaine and caustic potash, so far as he knew, are not soluble in vaseline, and if they are first dissolved in water, they cannot be thoroughly incorporated with the vaseline.

DR. LEWIS said the preparation referred to by Dr. Allen was suggested by Jennings, of the London Cancer Hospital. The speaker said he had frequently employed it and got the effect of the cocaine, but in order to obtain this it must be freshly prepared. It will not do to keep it on hand for any length of time. He would only recommend the application for the removal of very small growths.

DR. C. W. CUTLER said that vaseline will take up a considerable amount of water. He suggested that the cocaine be dissolved in a little water and then rubbed into the vaseline, after the addition of a little heat.

DR. LUSTGARTEN called attention to the fact that if cocaine be mixed with potassium, it is no longer cocaine muriate, but the alkalioid, and the latter would dissolve in vaseline.

A Case of Dermatitis Hemostatica.—Presented by DR. KLOTZ.

The speaker said that since 1891, when he read a paper on dermatitis hemostatica before the American Dermatological Association, he had been waiting for a chance to present to the Society an uncomplicated case of this condition. He now presented this patient as a case of atrophic dermatitis hemostatica. The history was as follows: Male; 25 years of age; a bartender by occupation. About three years ago he noticed a brown discoloration of the skin on his left leg, which has gradually increased in size. It has never caused any sensation, neither itching nor pain, but the spreading of the affection has alarmed the patient. He has consulted several physicians without obtaining any relief and he avers that none of them seemed to be decided about a diagnosis.

In the centre of the front aspect of the left leg there appears a dark, brown spot, somewhat larger than a silver dollar, darker in the central portion, but of a lighter tint towards the not well defined periphery. On closer inspection the coloring is not uniform throughout, but lighter spots and small, polygonal designs of darker shade can be distinguished. In the peripheral portion, and more disseminated in the surrounding skin, single light brown dots, from pin-head to hemp-seed size, can be seen. Within the affected area the surface is perfectly dry and smooth. When the patient first came under observation about six weeks ago, a number of small, thin flat scales were noticeable, but these have disappeared under the application of salicylic soap plaster. The cutis itself and apparently the epidermis are decidedly atrophic. Dilated blood vessels are visible. The whole leg shows numerous small distended veins and capillary branches. In some localities fresh hemorrhagic foci can be found.

In conclusion, Dr. Klotz referred to a case of this affection presented by Dr. Cutler at the 202d meeting (JOUR. OF CUTA. & GEN.-URINARY DIS., Jan., 1891), which at the time induced him to study these not very rare cases more closely.

DR. CUTLER said that several years ago he had presented a similar case for diagnosis. He had not seen his patient recently.

DR. BRONSON said he could not understand why such a case should be spoken of as a dermatitis. A dermatosis, he thought, would be more applicable.

DR. KLOTZ said he agreed with Dr. Bronson that the name dermatitis hemostatica was not a very good one. The cases are rarely uncomplicated; the condition is often seen combined with an eczema, with which disease it is frequently confounded. In the case under discussion the lesions have led to atrophy of the skin. He did not believe that the simple absorption of a small hemorrhage could produce such an atrophy, but that a certain new formation of cells and tissue must previously take place.

DR. PIFFARD referred to a case of dermatitis hemostatica recently reported in an English Journal, although not under that name. The case was that of a surgeon whose skin became inflamed when blood from a patient came in contact with it. An erythema appeared after the blood was washed off.

A Case of Multiple Melanotic Sarcoma.—Presented by DR. A. R. ROBINSON.

The patient was a man 38 years old. His disease commenced about three years ago. At that time he had a mole on the back which gave rise to considerable itching and which gradually grew larger until it attained the size of a marble. He then consulted a physician, who tied off the growth with a string; the outer portion thereupon dried up and was cut off. A few months later a second growth appeared on the anterior surface of the arm, and a third one on the left shoulder. Now he has a great number. The primary one has not grown and is very small. Some of them are of pin-head size. The inguinal glands are markedly enlarged. The speaker said the man was at present taking the bromid of arsenic and gold (arsenauro).

DR. CUTLER said that in quite a number of cases he had employed a combination of the bromid of arsenic and gold with excellent results. The patients appear to bear the arsenic better in that form.

DR. PIFFARD said he had used the bromid of arsenic in solution, and the bromide of gold triturated, giving the drugs separately. The bromid of arsenic he rather liked; the bromid of gold he had never found any better than the chlorid where gold was indicated.

DR. FORDYCE said this case illustrated the well-known fact that a melanotic tumor, if not completely removed, was apt to be followed by metastatic growths. He had under his observation recently a man about thirty years of age, who had a pigmented mole on his arm, about as large as the end of a man's thumb. Five or six years ago the mole was injured, and ever since it had discharged a melanotic fluid which dried on the surface in the form of crusts. The question

arose whether it should be removed or left alone. If removed, was there danger of metastasis occurring? Several children of this man have similar tumors on the body.

DR. ROBINSON, in reply to a question, said he took it for granted that the primary growth gave rise to the secondary ones, which he regarded as metastatic. The primary tumor was in the skin, while the others were situated deeper down. The glandular enlargement also indicated a metastatic process.

DR. ALLEN said he always advised that melanotic tumors be excised in early life, if possible, to avoid accidental injury later such as had occurred in this case.

DR. PIFFARD also expressed the opinion that the sooner melanotic growths are removed the better.

DR. SHERWELL referred to a case of multiple pigmented sarcoma coming under his observation where the lesions were principally confined to the lower limbs. He was put on increasing doses of arsenic and got entirely well, remaining so for at least a year, when he was lost sight of. If there had been any recurrence he would no doubt have returned for treatment.

Epidemic Skin Disease. (SAVILL).

DR. FORDYCE showed colored drawings of two cases and referred to several similar cases under his observation at the City Hospital which presented many features of the epidemic skin disease reported in England by Dr. Savill. In the cases illustrated by the water color sketches the eruption began on the trunk as round or oval patches of scaling erythema, with a tendency to clear in the centre and to extend peripherally. The eruption rapidly spread over the entire body, forming diffuse areas of redness with slight desquamation.

On the lower extremities the eruption was slightly moist in places, but there was little exudation. The eruption disappeared spontaneously with shedding of the epidermis in about six weeks from its onset.

Pruritus was a pronounced symptom in the majority of the cases. The general health was only slightly affected.

DR. C. W. ALLEN exhibited a new comedo-extractor devised by himself. It consisted of a forceps-like arrangement with a blunt end and a scooped-out middle portion, by means of which both vertical and lateral pressure could be exerted at the same time. The opposite end of the instrument consisted of a three-edged lance, the extra cutting edge being added to facilitate perforation of the walls of the follicles. A curette was also attached to the side of the shaft so that with a single instrument in the hand the various procedures required in a given case of acne could be carried out.

Report of Cases Presented at Previous Meetings.—DR. JACKSON reported that in his case of dermatitis herpetiformis he had stopped the arsenic and substituted phenacetin, and the patient had had no outbreak of any consequence since.

DR. LUSTGARTEN reported that his case of mycosis fungoides, presented at the previous meeting, had improved greatly under arsenic, as often happens in the early stages of the disease.

DR. FORDYCE reported that his case of lichen planus had almost entirely recovered under the use of arsenic and Unna's ointment.

DR. SHERWELL reported a case of scorbutus which recently came under his observation, and referred to the rarity of the disease at the present time, as compared with former years. The patient was a young child, the offspring of a poor, miserably-nourished woman. The patient suffered from constant bleeding of the gums, bleeding from the bowels, etc., presenting, in fact, a perfect picture of the old time classic scurvy.

NEW YORK ACADEMY OF MEDICINE.

SECTION ON GENITO-URINARY, JANUARY 12, 1897.

W. K. OTIS, M.D., *Chairman*.

Castration and Vasectomy in Prostatic Enlargement.

DR. F. TILDEN BROWN: In response to Dr. Chetwood's invitation to present a case bearing upon the topic that is brought forward to-night, I have asked this patient, whom I showed here about a year ago, to be present again. He is seventy-two years old. In August, 1895, he came to the Presbyterian Hospital with an enlarged prostate and complete retention. He was treated by rest and catheterization for about ten days without any benefit. He was still unable to pass a drop of urine. He was then treated to a trifling anterior urethrotomy, when a soft catheter of 30 French size could be substituted for the smaller one. That also failed to improve his bladder difficulty, and he was then subjected to double ligation of each vas deferens without severing and without any resection. The functional improvement which gradually followed this operation was surprisingly gratifying, and continued to be such while he was in the hospital. I have kept track of him since he left, and he is still in a very blissful condition. He uses a catheter once during twenty-four hours, and voids his urine comfortably without pain at varying intervals. Sometimes he gets up once at night, sometimes not at all. During the daytime his urinary intervals vary from two hours to a little more. The urethral distance has persistently been about 9 inches or a trifle less. The other day, when he answered my note about coming here to-night, he appeared at the office and there passed his urine before me, after which I used the catheter and found only 1 ounce of residual urine. When I reported this case a year ago, I said I was finding from $2\frac{1}{2}$ to 3 ounces of residual urine. I did not examine the rectum on his last visit, and I cannot say whether there is any diminution in the size of the prostate further than that slight reduction noted eight or nine months after the operation.

DR. HOWARD LILIENTHAL: As to the technic, in all cases I have castrated where the testicles were normal have been through the high incision. By this incision you can easily, where the testicle is normal, strip out the entire parietal tunica vaginalis as well as remove

the testicle in one piece. This removal of tunica is an advantage because it prevents exudation from the membrane afterwards and therefore hastens healing.

I also wish to record here a case where operation was performed a year and a half ago. There was an improvement in symptoms, but the patient for the last year has had a most persistent and trying pytalism, which begins at about four o'clock in the afternoon and continues throughout the entire night, so he finds great difficulty in sleeping. He has to spit constantly. A vessel stands beside his bed, in which he spits, and the amount of saliva he secretes is enormous. It is decidedly interesting to note that the apparent connection between the testicles and the salivary glands is occasionally met with in inflammatory diseases such as mumps. I have never heard of a case similar to this one and therefore report it.

DR. L. BOLTON BANGS: It seems to me that it is by an accumulation of experience that we shall arrive at a basis for practice in regard to this question. Therefore it should be discussed by everyone. There are men here now, I believe, who have been doing these operations and whose results ought to be placed on record. I speak now only in regard to this question of ligation of the vas deferens. I will reserve the question of castration for some other time.

In regard to the resection of the vas deferens which Dr. Chetwood has presented, there is not enough yet on record to draw conclusions from. I have had four cases. They are all living, but the results are not very satisfactory. One case of an old gentleman, eighty-two years of age, I have been able to get no statement of any improvement whatever. He urinates just as often as he did before. Unfortunately, he lives in a distant city, and I cannot determine the question of the amount of residual urine.

Another, a man of seventy-three, was resected last spring. There has not been the least change in his condition. He had already been introduced to catheter life, and in that way is rendered tolerably comfortable.

The third case I got a report from recently. He is still in about the same condition. It is only by persistency in regular and systematic catheter life, with daily washings, that his life is rendered comfortable.

The fourth, a man of sixty-nine, has an interesting and peculiar history. When he came under my care his prostate was very large—twice as large as normal—very hard, and extremely sensitive. He was suffering intensely. The prostatic urethra was so sensitive that catheter life could not be entered upon. Each effort at urination was accompanied by the most violent tenesmus. His whole being seemed to be engaged in an effort to force out a few drops of urine. At the same time he had the most intense burning in the soles of his feet. It was difficult for him at times to say which gave him the most distress, the burning in the feet or the pain on urination. It was found that he had a chronic interstitial nephritis. He was a delicate, feeble old man, and after trying all sorts of measures, including cystoscopy, and believing that prostatectomy or castration

would be fatal, I proposed resection of the vas deferens. At first there was no ameliorization. I kept him in bed, tried to catheterize him, but without result. This went on for about two weeks, but in this time I made another observation which was very interesting to me. I endeavored to get some result by massaging his prostate and examined the fluid pressed out on each occasion. To my great surprise I found some living spermatozoa in this fluid which was pressed from the prostate. I concluded to follow this up. I had him come, and repeated the operation every three or four days, until suddenly the spermatozoa disappeared, and almost as suddenly an ameliorization in his symptoms appeared. That is to say, I was able to introduce the catheter without pain and gradually to get him upon catheter life. There was a diminution in the size and sensitiveness of the prostate, and there was a shortening of the urethra of about one inch. The pain in his prostate on spontaneous urination did not entirely disappear, but was lessened. The burning in the soles of his feet did disappear, and for a time everything seemed to be smiling. Then he had a relapse of pain in the prostate and burning in the soles of the feet. This I conclude was due to sexual excitement and coitus, which he was apparently unable to control. Then we went on again for a time and there was another period of relief. I am unable to deduce a theory from this case excepting that the living spermatozoa may have excited some hyperemia of the prostate. He is still under observation. He urinates about once in two hours; he has on the average two ounces of residual urine, but of late he has suffered again a relapse of pain in his prostate. He has been partially relieved by applications of nitrate of silver directly to the prostatic urethra. When I inspected this by means of the endoscope it was found to be pulpy, looking like raw beef, and the last attempt to make this application was very severe. He suffered greatly.

This is my experience in resection of the vas deferens. I am unable to make any deduction. From records made by hospital men some relief seems to have been obtained, but my own experience thus far is not conclusive.

DR. J. B. WALKER: A man, aged sixty-seven, came into the hospital for an operation to relieve his enlarged prostate, but before doing that I catheterized him about once in six hours, day and night. He was unable to pass any urine at all himself. With the catheter I got about three to six ounces. He was in bed over three weeks without any special improvement. Finally, two weeks ago, an excision of both the vasa deferentia was done, about $\frac{1}{4}$ of an inch removed from either side. Within about two days he began to pass some urine himself. Two weeks after operation he can pass all his urine with the exception of three ounces of residual urine. The testicle has not become very much softer than it was before the operation. The prostate, which was hard, large, and tender, has become softer, and the catheter goes in now with much less effort. At first I was able to pass the catheter only by inserting a finger in the rectum and passing it along as a guide, but now a No. 12 enters without any difficulty whatever.

DR. KAMMERER, Mr. President: I shall not enter upon the cases of castration I have had, though I have had a few, but I would like to report two cases of ligation of the vas deferens; in the one case, a man of sixty-five years, with a large prostate, I had no result at all. This patient I was able to observe for about four or five months. There was not the slightest ameliorization in his condition. The second case, with acute retention, which had been lasting for three weeks, had an enlarged prostate and was in a very sad state indeed. The next day after operation he was able to pass his urine, and while I could only observe him for three weeks in the hospital—he left then—he passed his urine during that time, and it seemed to me that at the end of three weeks his prostate had decreased considerably in size. I fully appreciate that the larger portion of my observation has an unsatisfactory element in the case, but the result was extraordinary.

DR. CHETWOOD: In conclusion, I would say regarding these two procedures, that the operation of vasectomy is so simple a matter, I am sure we would all welcome it with a great deal of satisfaction if its value could be proven as a means of relief for the symptoms accompanying prostatic hypertrophy; but in the cases which I have read in the journals and the few I have seen personally, I am led to believe that the relief has been due more to the enforced regular catheterization and laying up, rather than to the operation itself.

In regard to castration there seem to be conflicting opinions in the report of cases. Some cases are reported favorably and others seem to show no relief from symptoms. I had hoped we would be able to reach a satisfactory conclusion as regards just what kind of cases were suitable for castration, but while the subject has been discussed and summarized by Dr. Cabot of Boston, and Dr. White of Philadelphia, the question seems still to be an open one, and it is only by an accumulation of cases reported that we shall be enabled to reach reliable conclusions.

There is always danger in introducing a novel procedure of this kind of being too enthusiastic, to the detriment of the patient. I found evidence of a stricture of wide calibre in my case and employed the sound regularly before operating. I recall a case which is fresh in my mind who almost became the victim of over hasty judgment. He had had several attacks of retention of urine, and was unfortunate enough to be of the age when prostatic hypertrophy generally ensues, and when he applied to one of the principal hospitals in Brooklyn for treatment, double castration was suggested to him as a means of relief for his symptoms. He being a married man wrote home to his wife for advice on the subject, the result of which was that he left the Brooklyn hospital and came to New York for further advice. Dr. Keyes being absent, he was seen by me and subsequently by Dr. Keyes, and examination revealed the presence of a stricture at the bulbo membranous junction. The gradual and complete dilatation of this stricture resulted in the entire relief of the patient's symptoms, and he returned home to his family happy in

the possession of both his testicles. It is now a year past since he applied for treatment, and he has had no return of symptoms.

While my own case speaks somewhat in favor of castration, I believe the operation of prostatectomy in suitable cases, will, when skillfully done, outlive the method of castration, where operation become necessary for the relief of prostatic hypertrophy.

Selections.

CUTANEOUS DISEASES.

Erythema Multiforme of the Buccal Mucous Membrane. LUK-ASIEWICZ (*Wiener klin. Wochenschrift*, 1896, ix, 23).

In the two instances reported, the erythema was found on the mucous membrane of the mouth alone, the skin remaining free during the whole course of the disease. Spots varying in size from a pin-head to a pea appeared on lower lip, cheeks, and gums. They were grayish, superficially eroded, and bled easily. Vesicles and ulcerations were seated on the soft palate. In two other cases, the membrane was attacked in conjunction with the skin outbreak. The author thinks the mouth may be the point of infection in such cases. Diagnosis is established by the acuteness, superficial character, peripheral extension, and early erosion of the erythematous elements.

Metastatic Exanthemata Due to Septic Infection. MEYER (*Arch. für klin. Chir.*, Bd. 2, Ht. 1, 1896).

After reviewing the literature, the author thinks that the only conclusion legitimately to be drawn from it is that evidence is in favor of the view which holds that exanthemata are metastases of cocci. The proof is yet lacking as regards contagious diseases, but in cases of sepsis and pyemia the same bacteria have been found in the skin lesions as in the original focus of disease.

An instance of staphylococcus infection is reported in which true metastases formed in the skin from a general process. Intracapillary masses of cocci were found, to which the exanthem was undoubtedly due, and which were carried in the blood-current to the skin. The youngest lesions, where inflammation was most acute, showed cocci in the papillary portion, not in the epidermis. The hair follicles were unaffected; a differential diagnostic point from impetigo. In the latter, the follicles offer an avenue of entrance to the bacteria.

Impetigo Herpetiformis. GLAEVECKE (*Arch. für Gyn.*, Bd. 211, Ht. 1, p. 18).

The disease appeared, as it has done in every instance of the few reports except two (one a man, the other a nullipara, who was twice

afterward attacked during pregnancy), in a pregnant woman. About the middle of the period of gestation there appeared, first on the abdomen miliary, pin-head sized, greenish pustules on a red and infiltrated base, in groups which coalesced. The center healed and peripheral extension took place. After drying and falling of the crusts, the pustules left pigmented spots. In places the skin healed; in others the usual vegetations developed, especially in the groin and about the navel.

Microscopic investigation showed a small-celled infiltration of corium, and especially of the papillary body. The papillæ were widened, the rete pegs widened and lengthened. In the deeper layers the vessels were dilated, their adventitia markedly infiltrated. Lymph channels were likewise dilated; sweat and sebaceous glands normal. The covering of the pustule consisted of the horny layer and part of the rete, the base of the papillary body and deeper layers of the rete being destroyed. Their contents consisted of serum, leucocytes, and epithelial cells. In healing, only the covering was lost; all the rest remained after absorption of the exudate. The staphylococcus aureus was found alone in the pustules, staphylococcus albus in the blood.

The eruption begins in the genito-crural folds and spreads until the whole body, except palms and soles, is covered. The hair and nails may be lost, and the disease may attack the mucous membranes, particularly of the alimentary tract. Erythema and urticaria often accompany it. Chill and fever herald a new outbreak. The latter may rise to 39° C. Pain, thirst, loss of appetite, convulsions, delirium, contractures, nystagmus, local paresthesia, diarrhea, bronchitis, pneumonia, and nephritis are among the concomitant symptoms. Occasionally the disease ends in death in one week; again, it persists for years, and the patient may undergo many relapses. Of twenty recorded cases, four only have recovered. The disease terminates only with the end of pregnancy, and the child is usually still-born. Prognosis is unfavorable. Treatment is symptomatic. Graevecke's patient was treated by terminating pregnancy and the continuous bath. She recovered.

Mycosis Fungoides with Initial Localization. HALLOPEAU and BUREAU (*Annales de Derm. et de Syph.*, L. viii, Nos. 8-9, 1896).

Eleven and a half years ago, the patient, a woman, showed only a single reddish, scaly, pruriginous spot, oval in shape, on the inner aspect of the thigh. At the end of three years, similar patches appeared on the trunk and legs. Two years since the arms were attacked, and then only vegetations developed. The lesions exhibited the usual indurated, polycyclic borders on the body, upper arms, and thighs, vegetating, and nodular in places. On the forearms the appearance was eczematous; on the legs, in addition, brownish pigmentation was seen. Spleen and glands were enlarged. The blood showed nothing abnormal.

"The initial localization on the thigh for three years before generalization suggests a portal of entry of the affection analogous to

that of syphilis and tuberculosis. In spite of the pruritus and periodical scratching, there was no development of prurigo. Points worthy of note are the polymorphism of the lesions and the vegetations found only at the border of the axillary and inguinal regions, where there seems to be a special disposition in the papillary body to proliferate."

Alteration of Peripheral Nerves in a Case of Erythema Multiforme. COSTANZO ROCCA (*Clin. Dermosifil. d. Univ. di Roma*, January, 1897).

The diagnosis was phlyctenular, infective multiform erythema, the lesions passing through the usual stage from macule to bleb. Some of them became annular in form. They were disseminated over the body and buccal mucous membrane, and in places exhibited a tendency to become confluent. Streptococci were found in the eruptive elements. Death resulted from complications—catarrhal broncopneumonia, fibrinous meningitis, parenchymatous nephritis, etc.

The median nerve of the left brachial plexus was examined histologically. It exhibited signs of inflammation, vascular dilatation, leucocytic infiltration, and proliferation of connective-tissue cells in both epineurium and perineurium. Individual fibers showed augmentation of nuclei in their neurilemma. The sheath of Schwann and axis cylinder were normal. Mononuclear leucocytes were found singly or in groups between the nerve fibers. The author thinks the interstitial neuritis may have had something to do with the outbreak of erythema.

Erythema Polymorphe. E. VON DURING (*Arch. für Derm. u. Syph.*, Bd. 35, 1896).

From his studies at Constantinople, the author divides erythema, in its widest sense, into three classes: (1) General infections, with symptomatic outbreaks on the skin. To this belong Hebra's *e. exsudativum multiforme* and *nodosum*. (2) Angioneuroses. The question of individual predisposition first enters here. The toxic erythemata form a part of this group, especially those of medicamentous origin. (3) Erythematous eruptions arising from embolism. Here is found the so-called "malignant polymorphous erythema," skin metastases from internal septic processes.

Dermatitis Pyemica. E. FINGER (*Wien. klin. Wochensch.*, 1896, No. 25).

Finger has observed five cases of pyemic exanthem which showed extraordinary polymorphism. They were caused by bacteria which reached the skin through blood channels.

1. *Dermatitis pyemica circumscripta suppurans*.—Two of the cases were classed under this head. Both were young children, who became pyemic in the course of a furunculosis. On section, small abscesses were found in the subcutaneous fat, with overlying nor-

mal skin. From furuncles, blood, and lung abscesses, staphylococci were cultivated. The blood-vessels formed the starting-point of the abscess, but cocci were not found in them. The author thinks the pyemia followed an infection through the blood from the furuncles.

2. *Dermatitis multiformis pyemica*.—Two cases. One was a woman with endocarditis and a papulo-pustular exanthem, who died. Staphylococcus cultures were made from blood and pustules. The vessels of the corium were plugged with them. The original focus of infection was the heart. The second case occurred in a young man with a phlegmon. An acute exanthema of papulo-pustules appeared, and he finally died of pneumonia. Streptococci and staphylococci were found in heart and lung; staphylococci alone in the papules. Histological findings were the same as in the previous case.

3. *Dermatitis pyemica hemorrhagica*.—One case, a young man with endocarditis and a maculo-papular eruption whose elements became hemorrhagic. Other areas of extravasation appeared. After death the streptococcus was found, miliary abscesses in fat and connective tissue, and the vessels in the neighborhood plugged with microorganisms. Cocci were found free at the sites of hemorrhage.

Therapeutic Notes.

Calcium Chlorid in Itching.—DR. SAVILL (*Brit. Med. Journ.*, No. 1864, p. 732) gives the drug in twenty grain doses in water after meals. He has seen no absolute failures, but it remains to be determined in what class of cases it is most useful. In long-standing cases it should be tried for some length of time.

Vesical Injections in Anuria.—ALBESKY (*Bull. Gen. de Thér.*, 1896, p. 225) treated a case of four days' duration, due to spasm of the whole tract with a decoction of belladonna (1-50) with 10 parts of boric acid injected through a metal catheter. About two ounces were left in the bladder and ten ounces of urine were obtained. A second injection secured a copious flow.

Vaselin in Erysipelas.—KÖSTER (*Thér. Monatshefte*, 1896, s. 299) states that he has obtained as good results in 130 cases by covering the surface twice a day as by any method of treatment previously employed.

Pruritus Vulvæ.—RUGE (*Berliner klin. Wochensch.*, 1896, 18.) frees the genitalia from hair, washes out the vaginal canal with sublimate solution so that no pathological material remains and then covers the diseased spots on the vulva with 3-5 per cent carbolvaselin. The procedure must be repeated every 3-4 days until a good result is secured.

Oil of Turpentine in Rosacea.—OTTO BETZ (*Memorabilien*, ht. 5, 1896) on the principle of the cataplasim, uses rectified ol. tere-

binth. rubbed into the affected parts. He has cured several cases after 3 or 4 rubbings done once a day. This causes a loosening of the sebaceous secretion and sets up an active hyperemia in the tissues, promoting absorption.

Nosophen.—RUGE (*Monatsh. f. Pract. Derm.*, bd. 23, No. 5) finds the drug useful in open buboes, chancre, chancroid acting better than iodoform while the specific virulence of the ulcer remains. The healing over of excoriations at the site of pemphigus blebs is hastened and it is especially indicated as a dusting powder after phimosis operations because of its effect in lessening the tendency to erection.

Arrest of Smallpox in its Vesicular Stage.—BRYAN (*Med. Record*, July 10, 1896) maintains that pustulation is due to invasion by pyogenic cocci, and may be prevented by antisepsis. He disinfected the hands and arms of a patient with bichlorid (1-500) and hydrogen peroxid. They were then wrapped in boracic wool. The majority of the vesicles dried up without pus formation. No scarring resulted from these lesions.

FURMAN (*Med. Record*, September 5, 1896) treated two cases antiseptically. The vesicles were opened, the cavity touched with pure carbolic, and the whole surface bathed in peroxid, the skin being oiled to prevent irritation. The result in both was satisfactory.

The Conservative Treatment of Actinomycosis.—JOSEPH JURINKA (*Mittheilungen aus den Grenzboten der Med. u. Chir.*, Bd. I, Heft 2, Jena, 1896) treated three cases by the administration of iodid of potassium, with perfect results, the patients remaining well after a year. In two, the disease affected the jaw, and the author contrasts surgical treatment with his. The iodid does not act by destroying the fungus, as provided by inoculation. The author is unable to state whether its action is an alteration of the soil or a lowering of the vitality of the fungus.—(Transcribed from *Brit. Journ. of Derm.*, October, 1896.)

LJUNGGREN (*Norkiskt Med. Archiv*, No. 27, 1895, p. 1) has gathered twenty-seven cases of actinomycosis in Sweden. Thirteen were his own, and were treated by incision, curretting, and lavage with iodid of potassium internally in severe cases. The cheek, maxilla, neck, tongue and abdomen were the parts affected.

Sycosis.—(V. TILÉ, *Wratsch*, 1895, Nos. 21 and 22).—The diseased areas are not shaved. The hairs are closely clipped, each pustule incised and washed with sublimate (alcoholic solution, 1-100). Epilation is not practised. Judgment must be exercised as to the intervals between the treatment. At night, a zinc-oxid paste is used. (*Annals de dermat. et de syph.*, May, 1896, p. 771.)

Guaicolized Oil in Zoster.—DESCOTTES has succeeded in quieting the pain of an intercostal zona with one local application of guaicolized oil (equal parts) for a whole day and part of a night. Renewed inunctions soon brought about a cure. A little local burning and a lowering of bodily temperature for an hour followed the application.

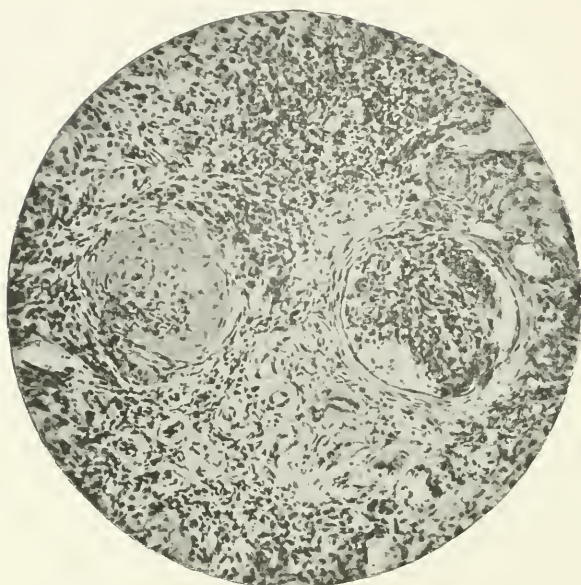


FIG. 1.—Two glomeruli in different stages of inflammation. The one on the right shows a thickening of Bowman's capsule, while the other shows almost complete degeneration of the structure. *Spencer* $\frac{1}{2}$ in. Projection ocular 4, *Zeiss*. $\times 150$.



FIG. 2.—Showing hyaline degeneration of a glomerulus and surrounding cellular infiltration. *Spencer* $\frac{1}{4}$ in. Projection ocular 4, *Zeiss*. \times circa 400.

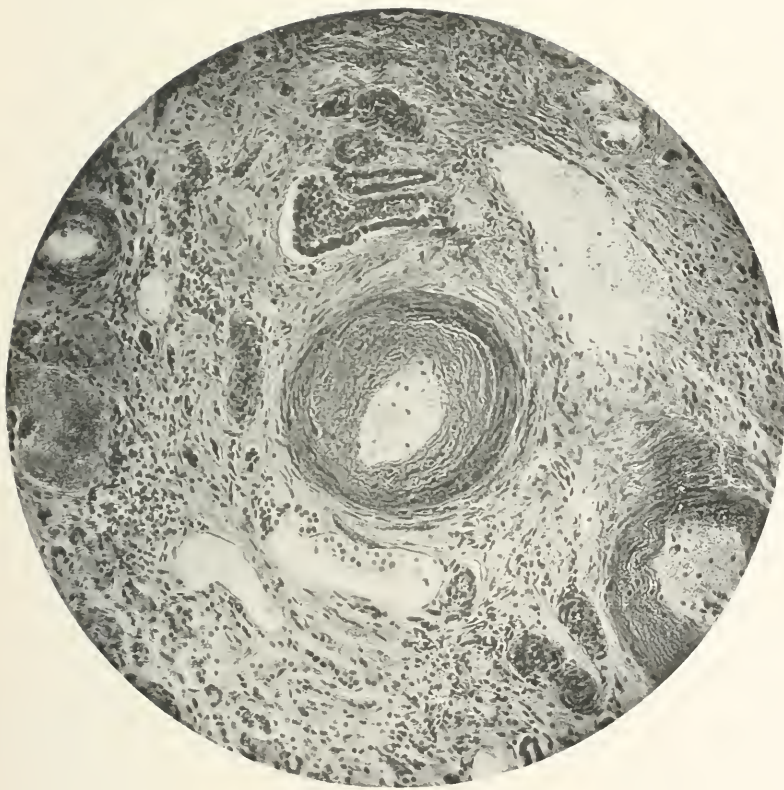


FIG. 3.—Endarteritis from a syphilitic kidney, showing thickening of all the coats of the vessel; the most pronounced change is seen in the intima. *Spencer* $\frac{1}{2}$ in. Compensation ocular 4, *Zeiss*. $\times 150$.

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Original Communications.

ON THE OCCURRENCE OF NEPHRITIS IN EARLY SYPHILIS: WITH THE REPORT OF A CASE TER- MINATING FATALLY.¹

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Visiting Dermatologist to the City Hospital, etc.

DURING the past few years clinical observers and pathologists have directed their attention more frequently to the relationship of the kidneys to constitutional syphilis than was formerly the case.

While amyloid degeneration of the kidneys resulting from syphilis had been described in 1840 by Rayer ("Traité des maladies des reins," Paris, 1840), it was not until a number of years later that the more characteristic gummatous tumors and interstitial changes in the kidneys were described by the pathologists.

Transient albuminuria, with or without edema, has occasionally been observed during the early outbreak of syphilitic manifestations.

A number of such cases have fallen under my observation which began before the use of mercury and disappeared during its administration.

This early syphilitic albuminuria has been attributed to a congestion of the kidneys analogous to that which takes place on the skin and mucous membrane; to alterations in the structure of the blood-vessels in the Malpighian tufts; to the irritation of the organs by the elimination of the products resulting from the destruction of the red blood-corpuscles which syphilis is known to occasion. It

¹ Read before the American Association of Genito-Urinary Surgeons.

has also been regarded along with the fever, icterus, anemia, etc., as the result of the action of a ptomain rather than of the specific micro-organism which we must assume to be present in the disease.

These early cases of albuminuria are usually of short duration, seldom giving rise to a persistent deposit of albumin in the urine or passing into a well-defined nephritis.

During the vigorous use of the inunction treatment both albumin and casts have been found in the urine, which disappeared when the inunctions were stopped and reappeared when they were resumed. We have good reason, therefore, to assume that mercury is at times responsible for the occurrence of albuminuria.

Aside from these cases of transient albuminuria in early syphilis, and the more carefully studied forms of amyloid, gummatous, and interstitial nephritis in the later stages of the disease, a number of observers as E. Wagner, Tommasoli, Jaccoud, Mauriac, Vulpian, Boukkeieff, and others, have noted the occurrence of an acute parenchymatous nephritis ushered in with fever, albuminuria, anasarca, etc., pursuing a course not unlike the nephritis of scarlatina, terminating at times in recovery, and again passing into a chronic interstitial inflammation with symptoms not to be distinguished from the non-syphilitic forms of the disease.

The following case, which was under my observation for nearly three years, affords an excellent illustration of this form of kidney inflammation in syphilis.

History.—The patient, an intelligent and robust laboring man of thirty-five years, stated that his previous health had always been good. He was not addicted to the use of alcohol.

He is married and the father of several healthy children. In December, 1888, without any assignable cause, a small pimple appeared on the ring finger of the right hand, which subsequently became larger and harder.

Early in February, 1889, the patient was seen by me and showed the remains of an indurated sore on the finger, together with a well-defined erythematous syphilide and generalized involvement of the lymphatic nodes. The genital organs were free from any specific lesion.

The use of mercury in moderate doses by the stomach was begun, and continued until April, when he presented a marked edema of the face and lower extremities, together with pronounced anemia.

He complained of intense headache and cardiac palpation. His urine was examined and found to have a specific gravity of 1030.

It contained one-third, by bulk, of albumin, and numerous epithelial and blood casts. The mercurial treatment, combined with the liberal use of milk, was continued until June, when the symptoms were found to be further aggravated. The lower extremities and scrotum were distended with fluid, which was also present in the abdominal cavity. The urine at this time contained nearly one-half its bulk of albumin, numerous casts, and some blood-corpuscles.

He stated that the vision of the left eye was impaired. At this time the administration of mercury was discontinued and the iodides given for a period of several weeks without obtaining any alleviation of the disease.

In September he was admitted to Bellevue Hospital, on the medical side, where, under the use of iron, alkalies, rest in bed, and a milk diet, his general condition improved.

At the end of six weeks he was discharged, with only a slight pitting on pressure about the ankles.

On December 15th he developed a right lobar pneumonia, followed by a persistent diarrhea.

His urine upon recovery was found to be smoky in color; to contain blood-corpuscles in abundance, with blood, epithelial, and granular casts. Its specific gravity had declined to 1015, and the amount in twenty-four hours was only eight ounces.

Uremic symptoms, headache, vertigo, dyspnea, and cardiac palpitation appeared and continued with varying severity until about the middle of February, 1890, when a marked improvement took place, permitting him to leave his bed and go about.

During the preceding six months very little mercury or iodide of potassium had been given. The skin eruption passed away and no other manifestation of the specific disease was present. From this time the daily quantity of urine increased. The specific gravity declined to about 1010, where it remained pretty constantly. Blood-corpuscles and casts continued in varying quantities. The tension in the peripheral arteries increased very perceptibly; physical examination revealed a hypertrophied heart.

An ophthalmoscopic examination showed several spots of hemorrhagic retinitis of the left eye; the right eye was found to be normal.

In April the patient presented a decided improvement in his subjective symptoms and general appearance.

Little edema was present. His urine passed in large quantities, was light in color, and contained a considerable quantity of albumin.

He passed from my observation at this time for over a year,

having obtained some light employment which prevented his attendance at the dispensary. The patient died three and a half years after the date of infection from uremic coma.

Autopsy.—An examination made twelve hours after death revealed the following conditions:

A generalized edema of the subcutaneous tissue was present. Only the abdominal organs and the heart were examined.

The kidneys were below the average size, the right weighing three ounces, the left about four.

The capsules were somewhat adherent, though not markedly so, coming away without tearing the cortical substance. A small cyst, holding about a dram, was found beneath the capsule of the right kidney. The surface of the organs was granular, and on section the tissue was firm.

During life the patient complained constantly of pain in the back over the region of the right kidney. It was interesting to find at the autopsy that the more marked changes were present in this organ.

A mass of bluish-gray tissue made up about half the bulk of the right kidney, which cut with difficulty and seemed to be composed almost entirely of connective tissue. The heart was hypertrophied, especially its left ventricular walls; no valvular lesions were found. Small pieces from both kidneys, hardened in Müller's fluid and alcohol, were cut and stained in the usual manner with hematoxylin and eosin, and borax carmine.

A section of normal kidney stained with these reagents and examined under the microscope shows almost exclusively tubules and Malpighian bodies; little connective tissue is present and the blood-vessels are not well demonstrated without special injection methods.

In sections from the case under consideration, few normal Malpighian bodies are found. The morbid changes are seen in all stages, from a slight proliferation of the endothelial cells lining Bowman's capsule, a marked fibroid thickening and compression of the vascular tufts, to a complete hyaline degeneration of these bodies. (Figs. 1 and 2, plate.)

Tests made with iodine and gentian violet failed to produce the characteristic amyloid reaction, a form of degeneration which suggested itself to me.

Throughout the kidney, especially in the cortex, sections of the vessels show marked implication of all their coats, more marked in the intima.

The caliber of the vessel is lessened by the new growth in this

membrane, which is made up of fine, wavy bundles of fibers, in which a few migrating leucocytes are seen. (Fig. 3, plate.) The hyaline change, which is most pronounced in the Malpighian bodies, is apparently taking place in the newly-formed tissue within the vessels, the cells of which stain faintly and are not well differentiated. The media and adventitia are also involved, the latter coat showing pronounced fibroid change.

This form of endarteritis, while found with especial frequency in syphilitic products, is not pathognomonic of that disease, as a similar or identical process is found in the ordinary or cirrhotic kidney. The new growth of connective tissue, which has compressed or obliterated many of the tubules, forms a prominent feature of the microscopic picture.

In places the connective-tissue growth, from the absence of nucleation, would seem to be of the same age; the greater part, however, is of comparatively recent formation, and scattered throughout the sections are numerous foci of small-celled infiltrations about the vessels, showing that the interstitial process was in active development.

A few tubules contain normal epithelium, in others the nuclei do not stain; the epithelium is granular and disintegrating, and in still others, hyaline and fatty casts are to be found.

An examination at so late a period after the onset of the nephritis could hardly reveal the starting point of the trouble.

A consideration of the clinical course of the malady, in connection with the anatomical changes in the organ, would lead one to the view that the primary change took place in the vessels of the glomeruli while attempting to rid the blood of the bacterial or toxic agent contained therein.

The researches of Klein on the anatomical changes in the kidneys from scarlatinal nephritis showed that the primary lesions take place in the glomeruli, resulting in a hyaline degeneration which renders many of them impervious.

The symptoms presented by my patient corresponded very closely with those met with in scarlatinal or those forms of kidney inflammation which follow the acute infectious diseases. It would be reasonable to suppose, therefore, that the anatomical seat of the trouble in the beginning of the disease was the same. The impression made by a study of the sections from the case in question is that the older lesions are in the Malpighian bodies, and the more recent in the connective tissue.

This sequence of involvement would explain the early occurrence of generalized edema, the partial suppression of urine, the large

amount of albumin, and the uremic symptoms. The secondary involvement of the connective tissue undoubtedly resulted from the long duration of the inflammatory process and the recurring attacks of subacute inflammation.

An effort was made to discover the presence of micro-organisms in the recent foci of round-celled infiltration, on the supposition that some infectious agent might be present; no success was, however, attained.

The case reported is, of course, open to the criticism that the nephritis was a coincidence and not a direct result of the specific virus, as it is readily admitted that syphilitic patients, like other individuals, may contract nephritis or other affections which are in no way related to the original disease. In the absence of other adequate causes, as diphtheria, scarlatina, other infectious diseases, or alcoholism, the probability is strong that it was directly related to the syphilis it so quickly followed.

The failure of the disease to respond to the medication employed would not invalidate this view of the case, as the prognosis in syphilis of the kidney, though less grave when occurring soon after infection than the more insidious forms of the later periods, is not so favorable as early syphilis of other organs. Prendergast (*Thèse de Paris*, 1892) has reported in full the case of a young woman who developed an acute nephritis four months after an initial lesion, and during the early eruption. In spite of the vigorous employment of the inunction treatment death took place within four months.

Mauriac (*syphilis tertiare*) has made a similar observation. A number of clinical observers have reported similar cases, and also examples of the termination of an acute parenchymatous nephritis (presumably of specific origin) into a chronic form of the disease, which persisted for years.

The observations thus far recorded would scarcely permit any conclusions to be reached as to the relative frequency of recovery of this form of early syphilitic kidney inflammation as compared with that following the other infectious diseases for which no specific remedy exists.

Since the foregoing case was observed a young man in the active stage of syphilis, with a generalized eruption and the induration of a recent chancre on the penis, was admitted to my service at the City Hospital. He was in a semi-comatose condition and presented a generalized edema of the subcutaneous tissue. A small quantity of highly colored urine was obtained by the use of the catheter. It was found to contain a large amount of albumin, with blood-

corpuscles, blood and epithelial casts. In spite of the vigorous employment of measures to relieve his uremic state he died on the following day.

An autopsy could not be obtained, and no satisfactory information was elicited regarding his previous health or habits.

I have, since my attention has been attracted to the connection of kidney inflammation with syphilis, noted the occurrence of syphilis in three patients with previous disease of these organs.

In one of them—a case lately observed—the eruption was of the large papular type and left deep brown, in places almost black, pigmentations after its disappearance. The pigmented spots were present on the face and trunk, and were more pronounced than in any case of syphilis I have ever seen.

It is more than probable that the nephritis, with which she had been affected for more than two years previous to her syphilitic trouble, increased the tendency to hemorrhages into the specific lesions.

It was noted also that the patient was unable to take mercury for any length of time without having protracted and troublesome pytalism. At the same time the amount of albumin increased in the urine, its quantity diminished, and she complained of severe pain in the lumbar region.

When we consider that the kidneys, as well as the bowels and salivary glands, are concerned in the elimination of the mercurials, it is not surprising that a nephritis is a serious impediment in the successful administration of the drug.

From the investigations that have been made up to this time, it would appear that aside from the presence of gummata and localized interstitial changes in the kidneys, there is as little characteristic in lesions of these organs produced by the disease as in the symptoms presented during the lifetime of the patient.

It is not my intention, in recording this case, to exaggerate the rôle of syphilis in giving rise to an acute parenchymatous nephritis, for the experience of clinicians in general, together with the carefully prepared statistics of Bamberger, Fürbringer, Weland, and other writers, have shown how seldom even a passing albuminuria is met with in the early stage of the disease, and that a well-marked nephritis at this time is of extreme rarity.

66 Park avenue.

A CASE OF DERMATITIS HERPETIFORMIS FOLLOWING VACCINATION.

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WITH a disease like dermatitis herpetiformis, whose etiology is still involved in much uncertainty, every case seems worthy of record that can be traced to a definite determining cause; this would seem to be particularly true of cases due to unusual causes. The following case, therefore, is reported in detail; first, because it is clearly traceable to vaccination as the determining factor in its development, and, second, because it has been under observation for $4\frac{1}{2}$ years—from the time of vaccination to the present—a period sufficiently long to satisfactorily establish a diagnosis.

For permission to publish the case I am indebted to Dr. Louis Becker, who referred the case to me, and to whose record of its early history, which he kindly put at my disposal, it owes its chief interest. Dr. Becker published a report of the case in the *Tri-State Medical Journal* in May, 1893. I cannot do better than repeat his excellent description of its early course:

"September 19, 1892, I vaccinated at one time four children in one family, the oldest of whom was a girl of thirteen. The points were charged from two different sources to make them doubly sure of effect, and I have the affidavit of Chas. Truax, Green & Co., of Chicago, that they were fresh and that the utmost care was observed in their preparation. The points were received from the above firm September 3, 1892, and were thus a little over two weeks old. These were kept in a cool, dark place. Three of the children went through their vaccinia with no undue disturbance. The girl spoken of had a typical scar and was doing nicely until October 30, 1892. On that day her mother consulted me in regard to an eruption in the hair and on the back of the neck, which I supposed from her description to be an eczema. The girl came to see me the next day and I found the back of the neck pretty thoroughly covered with vesicles from the size of a pea to that of a bean. Some of these were becoming confluent. They were surrounded by a faint areola and there was some itching present. The lesions were extending pretty thoroughly up into the hair. In three days they had so thoroughly invaded the scalp that the hair was cut off. They were beginning to appear on the back

chest, and arms, and were becoming much larger (the size of a hickory nut). The contents of the first vesicles, which originally was a clear serum, was decidedly milky. They were also becoming more confluent, so that the back of the neck at first sight looked as though it was covered with one large pustule.

"Within a week the vesicles were appearing thickly on the genitalia, and less thickly on the thighs. Those on the thighs were fully as large as a good-sized walnut, and there was here no tendency to become confluent. Those on the back of the neck had become decidedly pustular and were beginning to rupture. Many new but comparatively small vesicles were appearing on the face and front of the neck.

"In ten days the neck was covered with crusts which had that peculiar 'stuck on' appearance spoken of by Fox. That is, the crusts curled up at the edges and were adherent in the center alone. The back of the neck and the back were the only places in which the crusts had this "stuck on" appearance. The vesicles were each now going through the development into pustules, and the vesicles were appearing on the legs and feet, and were very large. A number were as large as a hen's egg, two or three were as large as an apple, while one on the back of the leg held a teacupful of pus when it was ruptured. They were now appearing on the hands and feet, even the soles of the feet and the toes showing great numbers of fine discrete vesicles. At two weeks the body was a pitiable sight, as the scalp, the back of the neck, and the entire back were covered with crusts, presenting the exact appearance of a severe eczema. The face was so covered with pustules as to hardly resemble a face. Even the lobes of the ears were covered with them, and a few small ones appeared in the canal. The chest and abdomen showed very many and good-sized pustules; the genitalia were covered with them; the legs and arms showed many discrete but very large vesicles, while the hands and feet, even to the palms and soles, were covered by fine vesicles.

"Three days later photographs were taken. Unfortunately, they are only valuable to show the extent of the disease which was now on its decline. The photographer's eyesight was poor and the focus was all wrong. The face was improving rapidly, but each of the vesicles ran a course of ten days or two weeks, the larger persisting the longer. In about five weeks she was pretty free from its effects. Her general nutrition was good during the whole time, and her parents thought that she would have had better health than usual but for the breaking out which rendered every movement painful. There

was no fever; appetite was good; bowels moved regularly; sleep was sound, and urine normal in every respect.

"We now looked upon her as in a fair way to recover and I had discontinued my attendance, when, after a restless night, she was found to be pretty thoroughly broken out with vesicles in size from a millet-seed to a split pea, covering portions of the face, the chest, and arms. There was no areola and after they ruptured only a very faint red base which disappeared in a few hours. They were all gone the third day. In three days more the same vesicles reappeared somewhat larger and over a wider extent. We now diagnosed a pemphigus. This disappeared as soon as before. It reappeared again and again, gradually growing more severe. We were now able to see, shortly before the vesicles appeared, a faint rash very much like a faint but very thick-set measles rash. It continued reappearing about twice a week in spite of the most sustaining treatment as advised by all the text-books in my reach. By this time, at each successive outbreak, the body was literally covered to the ends of the fingers and toes. On the fingers the vesicles were so large and thickly placed that the hand was spread out like a duck's foot.

"At this time I chanced upon a suggestion of Hutchison's to use Fowler's solution, not in ordinary doses, but so as to keep up puffiness under the eyes. It worked like a charm. The outbreaks grew less in extent very rapidly, and finally failed to appear at all except occasionally about the genitalia. This continued all during the winter. She was up and helping her mother with her household duties and her parents said her health was better than it had been for years.

"In February, it broke out somewhat again, and I found myself displaced as physician because of a laudable desire on the part of the father to end his days without work by contributions legally obtained from me. He rapidly employed one physician after another, and at last accounts had 'hied himself' to the tender mercies of Sarsaparilla, and she is still no better."

The case first came under my observation May 25, 1895, over two years and a half after its beginning. During this time the disease had persisted and had pursued the general course described above; the eruption usually of a vesicular-bullous type, marked by exacerbations and remissions, seldom or never entirely absent, and, at the time of the development of new lesions, accompanied by burning pain. Her general health had remained good. She was fourteen years old, somewhat undersized, anemic, and very slim, quick, and active mentally, and distinctly neurotic. Her functions were all in good condition; appetite and digestion good, bowels regular, urine

normal. She had never menstruated. She had never been a vigorous child, but had had no serious illness. Previous to vaccination she had never had any cutaneous eruption, except the common exanthemata. Her family history was unimportant. Her father and mother, three brothers and three sisters were living, all in good health, and there was no history of any skin disease in the family. None of the other children had suffered from any eruption either at the time of vaccination or subsequent to it.

When I first saw her there was present an abundant and widely distributed eruption of bullæ, vesicles, and erythematous and pigmented patches, lesions being present in all stages of evolution. The blebs were round or oval, and usually small from the size of a small pea to that of a hazelnut. The few larger ones were from the size of a partridge egg to that of a large walnut, these latter being formed usually from the confluence of adjacent blebs. The larger blebs were grouped, but were usually separated by narrow areas of erythematous skin; the smaller blebs and vesicles occurred in groups of closely aggregated lesions, at first discrete, then tending to become confluent. In the early stages the lesions were tense and filled with clear to opalescent serum; they were situated upon an inflamed base and were surrounded by a narrow inflammatory areola. They showed no tendency to rupture spontaneously, but on the flexor surfaces, and generally where the external wall was very thin, they were usually ruptured by contact or friction. The development of the eruptions was very sudden, the lesions attaining their full efflorescence in from six to eight hours. Preceding the evolution of a patch there would be for a short time a feeling of tension and burning; then the rapid appearance of a group of closely aggregated minute papules on an erythematous base, and then the development in a few hours of full-sized vesicles. The evolution of a group of lesions was, in fact, identical in appearance with that of a patch of Zoster, first vesicles and blebs filled with clear serum, this becoming cloudy, then puriform, then drying up, and the crusts exfoliating, leaving a reddish stain which persisted for some time; the course of a group of lesions, or a single bulla, usually extending over from eight to twelve days. The discrete larger bullæ pursued about the same course, the contents more often becoming purulent, particularly about the face and hands where inoculation was likely. The sites of previous lesions were marked first by erythematous, then by faintly pigmented stains which were very slow to disappear, so that her body was always mottled with them. There occurred at times upon the front and back of the trunk, where the other lesions were least abundant,

crops of macules and erythematous patches. These were of irregular size and shape, and usually lasted for a short time, two to three days at the longest. All the lesions developed without any ascertainable local cause; local irritation and traumatism seemed to play no part in their appearance. The distribution of the eruption was general, and was constantly characterized by symmetry, a group of lesions on one side of the body rarely failing to be accompanied by a group similar in type and location on the other. The eruption was most abundant on the face, the arms hands, axillary spaces, the feet and ankles, the groins, and around the genitalia. The hands, particularly the palmar surfaces, and the feet and ankles, were usually most violently affected, the lesions in those locations being often discrete tense bullæ, of the size of a hazelnut to that of an olive, with a wider inflammatory areola, and associated with much pain. The bullæ were of frequent occurrence in the roof of the mouth and at the border of the tongue. The occurrence of lesions in any location was usually associated with swelling and tenderness of the corresponding glands. In distribution the eruption did not show any tendency to follow the course of cutaneous nerves. About the genitalia, the axillary spaces, the elbows, and the front of the knees, for all of which sites it showed a predilection, the eruption usually occurred in Zoster-like patches of pea-sized bullæ, or of minute vesicles. This grouped arrangement of the lesions was one of the constant and most striking characteristics. It was usually in irregular patches, from one-half to four inches in diameter, or in crescents or segments of circles. The figures at times were almost complete circles, and again the conjunction of neighboring figures often formed striking gyrate patterns. The lesions did not appear in iris-forms.

The subjective sensations associated with the eruption were confined to a feeling of tension, tingling, and burning pains, most severe at the onset. In the case of the groups of smaller lesions this sensation was moderate stinging and burning. In the larger ones it amounted to very severe burning pain, sufficient at times to keep the patient in tears during the evolution of new lesions, and to interfere greatly with sleep. These sensations were much relieved by puncturing the bullæ. The development of a new crop of lesions was, as a rule, preceded by a day of nervousness, irritability, and peevishness, or by a night of restless sleep. At such times, and until the active stage of development was passed, there was copious palmar hyperidrosis; and, at the same time, there was increased frequency of urination, and the passage of an increased quantity of pale, limpid

urine of low specific gravity. There were never any lesions which could be attributed to inoculation or traumatism; the patient, indeed, did not scratch or handle the skin in any way, except to nurse most gently the new lesions until they were relieved by punctures.

The patient entered the Chicago Hospital May 25th. She was placed under the best hygienic conditions and was given a liberal diet. After some trial of other applications she was put upon a sulphur and vaseline ointment and daily baths of potassium sulphid; internally she was given Fowler's solution in increasing doses in conjunction with other tonics, chiefly iron, quinin, and strychnin. This general line of treatment was followed during the eighty-one days that she was in the hospital. Within two weeks her skin was entirely clear, except for the presence of stains. It remained clear for about ten days. Then without any ascertainable cause new crops of lesions began to appear, and during the rest of the time she was rarely, if ever, entirely free from the eruption. The eruption was not so abundant as when she came in, but it pursued the same general course until she left the hospital on August 19th. During this time her health remained good, apparently unaffected by the condition of her skin. Her appetite was good, bowels regular, temperature from 98° to 100° F., urine acid, of specific gravity 1010 to 1018, and free from albumen or sugar. For about a year after this, I am informed, her condition remained the same. Within the last year she has improved very much, and for several months she has had no eruption except about the face and hands; in these locations it is seldom absent, and is worse during menstruation.

The diagnosis of dermatitis herpetiformis in this case is based upon the general course of the disease, the constant tendency of the lesions to arrangement in groups, the polymorphic character and inflammatory features of the eruption, the marked subjective symptoms accompanying the lesions, the evidences of general nervous instability, and the comparatively good health of the patient throughout the course of the disease. From the general forms of impetigo, impetigo contagiosa universalis, impetigo contagiosa circinata, etc., and from so-called pemphigus contagiosus, and pemphigus epidemicus, and similar bullous eruptions which, it is fair to assume, arise in most cases from local inoculation, the case differs in its chronicity and persistence, in the nervous symptoms, and in the absence of any evidence of the spread of the disease by inoculation or contagion. Remembering the persistence of the disease apparently unaffected by local antiseptic treatment, including almost three months of systematic attention in hospital, and the entire escape from any similar

eruption, both at the time of vaccination and since, of the other children of the family, with whom the patient has lived in the intimate contact of poverty, the diagnosis of impetigo in any form would seem to be definitely excluded. From true pemphigus it is distinguished by most of the characteristics given as the basis for the diagnosis—the grouped arrangement, the inflammatory features, the polymorphic character of the eruption, the marked subjective symptoms, the course of the disease, and the comparatively good health of the patient. If our conception of pemphigus is to be enlarged, as Kaposi, judging from his discussion upon dermatitis herpetiformis at the German Congress of Dermatology in 1895, would like, the question of the diagnosis between dermatitis herpetiformis and pemphigus would apparently reduce itself to a discussion of names. But if we are to retain the classical conception of pemphigus, the classification of such a case as this does not seem to be doubtful. Pemphigus vulgaris, as understood until the hard-pressed opponents of dermatitis herpetiformis began to enlarge its conception, is a bullous eruption. The bullæ do not show a marked tendency to arrangement in groups, are without the inflammatory features, are not accompanied by marked subjective sensations, and the patient's general health is usually severely affected. In pemphigus vulgaris benignus, to use Hebra's own words, "the bullæ are tense and few in number. . . . If the bullæ do not happen to be situated where they are exposed to injury by pressure from the clothes, or in some other way, the patient is not at all inconvenienced by their presence." In pemphigus vulgaris malignus, to quote Hebra again, the disease is grave, "the patient's health becoming quickly affected. . . . This form of pemphigus generally terminates fatally." It is puzzling to see how such a case as this one can be included under either of these descriptions.

I have given this case thus fully in detail, because when there have been excluded the cases of general impetigo and of so-called pemphigus contagiosus, the number of cases of pemphigus and dermatitis herpetiformis following vaccination are exceedingly rare. A somewhat extensive, but not exhaustive, examination of the literature has discovered very few similar cases. Most articles on vaccinal eruptions mention pemphigus as a rare sequela of vaccination, but it is difficult to find the records of cases that will meet the requirements of an exact diagnosis.

Allen, at the meeting of the American Dermatological Association last year, reported a case of impetigo contagiosa universalis following vaccination, in which the history was very suggestive of dermatitis herpetiformis. In the discussion of the case, Dyer, of

New Orleans, mentioned four similar cases in his practice in which he had made the provisional diagnosis of dermatitis herpetiformis.

In the *New Orleans Medical and Surgical Journal* of October, 1896, Dyer published a case of dermatitis herpetiformis following vaccination in a negro. Inasmuch, however, as the case was of less than three month's duration, and left the hospital apparently cured, the diagnosis would seem not beyond question without further observation of its course.

I have not been able to find any other case following vaccination in which the diagnosis of dermatitis herpetiformis seems as well founded as in these. Taking into consideration, then, the universal practice of vaccination and the striking characteristics of dermatitis herpetiformis which would render likely the report of any cases following vaccination, there can be no doubt that dermatitis herpetiformis after vaccination is an excessively rare accident.

As to the etiology of this case, there would seem to be no reason for doubting that vaccination was the determining factor; that it was anything more I do not believe. Advocates of the toxic origin of some cases of the disease may find a confirmation of their views in this case. But it is hard to see how a toxin that produced a disease of as acute characteristics as this presented could exist with unabated intensity for five years. On the other hand it is not difficult to understand how vaccination might act as an exciting cause for an eruption of neurotic origin in a patient already predisposed to such a dermatosis. Indeed, it seems remarkable that we have not a larger list of cases of psoriasis, of pemphigus, and of dermatitis herpetiformis, and similar diseases of probably neurotic origin excited by vaccination. In the few such cases that we have it would seem no more reasonable, in the present state of our knowledge, to charge vaccination with being the essential cause, than it would be to charge bird shooting with being one of the essential causes of dermatitis herpetiformis, because in one of Dr. Duhring's classical cases we have an attack of dermatitis herpetiformis directly traceable to an unusual adventure while out shooting.

103 State Street.

A NEW OPERATIVE PROCEDURE FOR THE CURE OF
RECTO-URETHRAL FISTULA.¹

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New York.

Professor of Genito-Urinary and Venereal Surgery at the New York Post-Graduate Medical School; Visiting Genito-Urinary Surgeon to the City Hospital, etc.

THE usual urethral opening for recto-urethral fistula is on the floor of the membranous urethra anterior to the prostatic body, while the rectal opening is at the upper wall of the bowel behind the sphincter muscle. In this part under normal conditions the membranous urethra is separated from the rectum by a connective-tissue partition of only about one-fourth of an inch in thickness. This thin partition can be anatomically divided into three parts, the wall of the membranous urethra, the wall of the rectum, and a loose elastic connective-tissue meshwork, which allows the rectal pouch to expand and contract without reference to the membranous urethra. When, however, a fistula forms in this region, the intermediate loose connective-tissue is obliterated, and by cicatricial contraction the agglutinated urethral and rectal walls become much thinner than normal, so that the fistula can rarely have a length greater than one-eighth of an inch. In fact, it is not unusual, in one of these cases, a sound being passed along the urethra and a finger into the rectum, for the margin of the fistula to feel as thin and sharp as the blade of a paper knife. Most fistulæ of this nature result originally from traumatism, and if the destruction of tissue thereby, or the tear or cut be extensive, natural resolution will not occur, owing to the inherent quality of the tissue to retract.

Sometimes fistulous connection occurs between the prostatic urethra and the rectum, through the prostatic body. Prostatic abscess and perforating wounds are the usual cause for such a condition. Fistulæ of this last description generally close of their own accord, or tend to do so, if the bladder is relieved from urine pressure by catheterization, by the tying in of a catheter, or by the establishment of vesical drainage through a cutting operation.

Recto-urethral fistula, and by that is meant the ordinary kind, which connects the membranous urethra with the rectum, has always been considered very difficult to cure, and most surgical operations

¹Read before the Section on Genito-Urinary Surgery at the New York Academy of Medicine, March 9, 1897.

undertaken to relieve it have resulted in aggravating rather than in improving existing conditions. An early and most ineffectual operation consisted in stretching the rectal sphincter and in introducing retractors, thus exposing the rectal orifice of the fistula, the margins of which were refreshed and brought into apposition by sutures. Such sutures always give away, and as the cicatricial tissue about the margins is poorly nourished, some sloughing was to be expected. A later and more scientific procedure consisted of a lateral perineal incision above the rectum, and as long as the rami of the pelvis would admit, followed by a careful dissection which separated the urethra from the rectum along the line of the loose connective lying between these two structures. This dissection extended back beyond the fistula, splitting it as it were in its middle. Then the rectal sphincter was stretched to allow the free discharge of accumulations, after which the margins of the rectal end of the fistula are denuded and brought into opposition by sutures, which were put in position through the perineal wound. The membranous urethra was next slit up longitudinally on its floor, as in ordinary perineal section, the urethral margins of fistula refreshed, and a perineal drainage tube inserted, the perineal wound being left to heal largely by granulation. The results from this operation were rarely satisfactory, as in most cases the bowel end of the fistula would reopen; the final outcome being either a recto-urethral fistula again, or a recto-perineo-urethral fistula. After performing the last-described operation, in the early Spring of 1896, and getting the usual poor result, it struck me that the cause for my operative failure was twofold. In the first place, the rectal sphincter regained its tone too quickly, thus allowing distension of the rectum to occur, which tended not only to cause the bowel wound to open, but also to rob it of its needed vascular supply. In the second place, the sutured bowel wound lying in the bottom of the perineal incision, directly under the perineal drainage tube, was in a very unfavorable position for primary union, especially when one considered that the bowel wall had been rendered abnormally thin by the process of cicatrization. In this connection the operative procedure for the cure of vesical incontinence in the female, first practised by Gersung, of dissecting out the urethra, twisting it slightly, and then maintaining it in that position by sutures, came into my mind. By applying it to the rectum I saw that I could so shift the sutured bowel wound to one side that I could bring its inner surface against live tissue, where it would be freed from exposure, and nourished by the healthy tissue about it. Besides this it was evident that the plastic lymph, which would quickly secure the rectal

wall about the sutures to the lateral perineal tissues, would act as a most efficient factor in preventing leakage from the bowel in case the sutures gave way or a slight sloughing occurred about the margin of the bowel wound. To prevent the rectal sphincter from regaining its tone too quickly I determined to try the radical and well-established procedure of cutting through the muscle.¹

In August, 1896, in resuming my service at the City Hospital, the opportunity presented itself of putting to a practical test the ideas I have just enumerated. The patient, a feeble man of fifty-six, was the same individual on whom I had unsuccessfully practised the lateral perineal cut, followed by dissection between the urethra and rectum, and together with rectal suture in the preceding early Spring. His condition at this time was worse than it had been before the first operation. He was bedridden and in much pain. Fecal matter blocked his urethra, while urine trickled from his rectum through a fistula, capable of admitting the tip of the forefinger.

The previous operation, owing to the dense cicatrix which it had left, increased the difficulties in connection with further operative attempts. Taking it all in all, the case was an extremely unfavorable one of its kind from a surgical standpoint. After carefully cleansing the bowel, urethra, and bladder, the patient was put under ether and a circular cut made around the rectum about three-fourths of an inch from the margin of the mucous membrane. Gentle traction was then made on the rectum while a circular dissection outside the rectal sphincter was completed. The lower rectum with its sphincter being thus freed, the dissection was continued outside the bowel wall for a distance of about an inch and a half above the fistulous opening. Considerable care had to be used to separate the bowel wall from the urethra in the neighborhood of the fistula. In other places, however, the dissection was easy of accomplishment. The freed bowel being now drawn down, the rectal portion of the fistula was accessible. With scissors the sphincter and bowel wall were cut through up to the fistulous opening, and the edges of the fistula cut away. The fistulous opening now represented the apex of a V-shaped space. The angle of this space, down to the rectal sphincter, was then securely sutured with catgut, the sutures being passed from outside the bowel, and care being observed not to involve the mucous

¹ Since reading this paper my friend, Dr. James P. Tuttle of this city, has called my attention to an article by Ziembicki of Lemberg (*Cong. franc. de Chir., Proc. verb.*, etc., 1889). On looking up this reference I find that Ziembicki has reported one case where he practiced a procedure similar in principle to the one I advocate.

membrane. A longitudinal slit was next made on the floor of the membranous urethra, a grooved staff having been passed along the urethra to guide the knife. This slit was made to pass through the urethral end of the fistule, the edges of which were refreshed by means of a curette. A perineal vesical drainage tube was then put in position. The last step of the operation consisted in twisting the rectum so as to give the rectal end of the fistula a permanent lateral position such as has been described. To do this I rotated the bowel to the left, slightly over 90° , and maintained it in that position by numerous silkworm gut sutures, which secured the margin of the rectal sphincter to the perineal tissues. After the operation, finding that the patient was temporarily unable to expel his flatus, I had a soft rubber bowel tube inserted which answered its purpose. Shortly after the operation I went off duty at the hospital and did not see the patient again for several months, when I found him comfortable. He had a small urethro-perineal fistula which marked the course of the perineal vesical tube, which I discovered on inquiry, had been allowed to remain in situ for many weeks after the operation.

His bowel action was perfect, and, with the exception of losing some urine through the the perineal opening, only, however, at the time of normal urination, his condition was wholly satisfactory. I doubt if he would have had any perineal fistula had the vesical tube been removed, as I think it should have been at the end of a week. On another similar occasion I should dispense with a perineal vesical tube. I should depend for vesical drainage on a soft rubber catheter passed along the urethra and tied in position. Consequently I should not make a longitudinal slit along the floor of the membranous urethra, but should simply refresh the margins of the urethral end of the fistula with curved scissors or the curette.

Treatment of Lupus with Salicylic Acid and Creosote Plaster (*Monatsch. für prakt. Derm.*, xxii, February, 1896).—DUBREUILH and ZERNARD claim that this plaster has advantages, attacking diseased tissue alone. It consists of equal portions of the ingredients or a preponderance of creosote. It produces a transitory pain with each application, which is made after a day's interval. The whole diseased area is covered at once, the nodules ulcerating after three or four plasters. The method is not applicable in lupus sclerosus, and does not bring about a complete cure alone.

Clinical Note.

A CASE OF PHIMOSIS OF TRAUMATIC ORIGIN.

By CHARLES C. PAGE, M.D.,

New York.

GL., age forty-one, Norwegian, says that when an infant he was left on the floor in a very cold room, and after urinating his penis and testicles were frozen to the floor. When picked up his foreskin was lacerated, and in process of healing the preputial orifice became almost entirely closed by cicatricial contraction. Nothing was ever done to relieve the condition. At the age of thirty-four he married, and is the father of two children.

About six months before seeing him he began to complain of great difficulty in urinating, requiring several passages to empty the bladder. In December, 1896, he presented himself. The glans penis is entirely surrounded by foreskin, the parts resembling the closed end of the finger of a glove. When the penis is erected an inflation or "ballooning" of the foreskin takes place. At a point a little less than midway between the urethral orifice and corona is an opening in the prepuce, which does not quite admit the point of a small silver probe. This orifice is surrounded by a deposit of urinary salts, and has a hard, shotty feeling.

Circumscision was advised. Under cocain a probe was forced into the orifice and swept around, a director then passed, and the foreskin slit back to the corona and reflected. The mucous membrane was closely adherent for nearly two-thirds the circumference of the glans, especially so around the frenum, where it was too firm and thickened to be separated at all. The skin was trimmed around, and stitched to the mucous membrane wherever possible. The long-continued irritation of urine and smegma had produced firm adhesions and induration, and possibly would ultimately have produced some grave condition, when we consider the relation an unrelieved phimosis bears to epithelioma. In three weeks the parts had healed completely. The patient is of a rather nervous temperament, but since the operation he expresses himself as feeling much better, and has gained six pounds.

127 Liberty street.

Society Transactions.

THE THIRD INTERNATIONAL CONGRESS OF DERMATOLOGY AND SYPHILOGRAPHY.

(Continued from page 133.)

SPECIAL COMMUNICATIONS.

Remarks on Sarcoma of the Skin and Its Varieties.

SCHWIMMER (Budapest) compared sarcoma with several other skin affections having great clinical similarity. The term was used by physicians from Galen and the Arabians to Lorry and Ambroise Paré. Virchow first separated it from carcinoma and other neoplasms, but Köbner has the honor of priority in describing the tumor as it occurs in the skin. Twenty-five years ago Kaposi wrote his monograph on the pigmentary variety which bears his name. There exist at present two distinct types—the *surgical sarcoma* of Virchow and Köbner, which develops generally as a tissue change in some organ, and the *pigmentary sarcoma*, a far graver disease leading often to death by metastasis in internal organs. The author reported seven cases of his own, and compared them with lymphosarcoma, mycosis, and a form, still unnamed, which he called “false mycosis.” Two of his four cases of pigmentary sarcoma died, and metastases were found in the liver, lungs, and especially in the intestines. The ileocaecal portion was almost closed by a ring 6-8 cm. in length. Histologically, the tumors consisted almost entirely of spindle-cells, their nuclei usually staining well. Some, however, showed signs of a degenerative process tending to resolution, a point which may be accepted, in view of the fact that near these cells were portions in which nuclei were fragmented, or entirely absorbed. The sarcomata took their origin from the vessel-walls. Schwimmer cannot regard sarcoma and mycosis as identical. In the latter round cells prevail, rarely ever the fusiform. Its vessels are narrowed and lymphatics dilated—just the opposite of the sarcomatous condition. As to therapeutics, too great reliance cannot be placed on arsenic. Some of these cases were treated for years without the least effect. In others, he demonstrated resolution of the nodules without any medication.

A New Form of Acne (Acne Rubra Seborrhoicum).

PETRINI (Galatz) has recently seen two cases in middle-aged women. The disease appeared, in the first case, in the form of small red papules on the face, and especially the nose. After a time plaques were formed by their coalescence, and on these appeared thick scales. The skin was not infiltrated, and the rose color disappeared under pres-

sure. A linear formation appeared on the lips and chin. Tiny vesicles sometimes surmounted the papules, and the fat secretion was increased over the region. There was no sign of telangiectasis. In process of absorption the lesions exfoliated and left no cicatrices. The mucous membrane of the lower lip was congested and covered with dry desquamation; the same condition was present at the nasal orifices. There was slight itching.

The lesions in the second case had lasted ten years, worse in winter. She suffered from a milder affection than the first. The author excludes seborrhea congestiva because he watched the evolution of the acne elements. The disease yielded to treatment with sulphur and ichthyol in four to six weeks.

Onychorrhaxis.

DUBREUILH and FRÈCHE (Bordeaux). This is an affection characterized by extreme fragility of the nails, longitudinal furrows, and thinning. It is not rare, except in intense development. In the latter, the furrows are numerous, pronounced, and close together, and showing at their bottom a double fissure, which appears as though traced with a needle-point. The free border is serrated by longitudinal breaks, extending toward the base. There is no alteration in the form of the nail, its bed, or the circumungueal tissue. The duration is variable—a few years or a lifetime. Habitually a number of nails are attacked; quite often all of them. It is a trophic disturbance, due, apparently, to congenital and persistent nervous troubles, and coincident with anomalies of development or other nervous affections.

Surgical Treatment of Leucokeratosis Buccalis.

PERRIN (Marseilles), with the aid of the thermo- or galvano-cautery, has excised or destroyed patches of advanced disease. Several cases were under observation from seven to ten years, and the cure has been complete and durable. There was no recurrence on or near the site of the plaques, which were replaced by a firm, but supple, cicatrix. Surgical intervention is the only treatment certain in its results. It may be done under local anesthesia.

Lichen Ruber Acuminatus, or Verrucosus.

MAX JOSEPH (Berlin) believes that all are in accord on the lichen question, except the point of the identity of pityriasis rubra and lichen acuminatus. Accord, however, is far from being established on the anatomy of lichen ruber. In lichen planus, the youngest papules show a separation of derma and epidermis. Constancy of the appearance shows that it is not accidental. In the lacuna so produced are found prickle cells, a clot traversed by fibrin filaments, and numbers of mononuclear leucocytes. There is an infiltration of the deeper parts of the derma about the vessels. The epidermis is thickened at the border of the lesion. Umbilication is explained by a sinking in of the vesicle top. Pemphigoid cases are the result of its persistence.

In the acuminate variety, sections from a case showing plane lesions also, showed a hyperkeratosis, destined later to retrogression, a perivascular infiltration of the derma, localized about the follicles, consisting of mononuclear leucocytes, mast cells, and giant cells. The infiltration increasing caused changes in the hairs like those in pityriasis rubra. The principal difference between the two is the dermic infiltration in lichen acuminatus.

Lichen verrucosus shows an enormous thickening of the horny layer, as in a young wart. The derma is densely infiltrated, with a few mast cells. Later, hyperkeratosis diminishes with the infiltration. Histologically, the three forms are closely related, but the identity of pityriasis rubra and lichen ruber remains to be proved.

Xeroderma }Pigmentosum.

FALÇAO (Lisbon) reported a case presenting all the elements described by Kaposi in a woman of eighty-eight. Since the first, three others, in women of seventy-two, eighty-nine, and ninety years, have come under his notice. He reaches these conclusions: (1) Xeroderma may be manifested at an advanced age; (2) traces of the disease may be preserved, reproducing the type late in line; (3) at that time there is predominance of horny formations and atrophy, while in infancy pigmentation and ectasia are more developed.

Elastic Pseudo-Xanthoma.

DARIER (Paris) rediscovered the case described by Chauffard in 1889. The eruption began at twenty-six by a violaceous, then yellow coloration of the skin. It has progressed continuously, and now consists of large plaques on the sides, thighs, abdomen, and popliteal folds. The patches, lightly raised, are constituted by the confluence of little pale-yellow masses contained in a violet areola. The neighboring skin is less elastic than the normal. Isolated elements in the shape of little yellow papules show a lilac border, and in the center a pigmented follicular opening. One xanthoid patch appears at the angle of each eye, one on the upper lip, and others on the buccal mucous membrane.

The microscope shows a special and constant alteration of elastic tissue, which is disposed in confluent lobules occupying the whole corium thickness in the plaques; in isolated papules, it is seen about the sebaceous follicles. The fibers seem to be thickened, broken, and gathered into irregular, beaded bundles, to split sometimes, or vacuolate, and finally to dissolve into amorphous masses. Connective-tissue cells are increased. In the papillary body there is no lesion; a few pigment and mast cells. There were xanthoma cells, or fatty granulations, in the derma. There seems no reason for attaching this anomaly to xanthoma.

Iodid of Potassium in Secondary Syphilis.

BARBE (Paris) says that this use of the drug should be extended beyond its common employment in fever, neuralgia, cephalalgia, in

the general symptomatic pains of the secondary period, at least in certain cases. In spite of Mauriac's expressed opinion to the contrary, he treated a case with mucous patches which had resisted mercurial treatment for three months. The mercury was given by injection to the point of production of stomatitis. Two grams of the iodid a day were given, and the injections stopped. In a few days a change took place, and a complete cure resulted in three weeks.

NEW YORK DERMATOLOGICAL SOCIETY.

TWO HUNDRED AND FIFTY-SEVENTH REGULAR MEETING, HELD ON
TUESDAY EVENING, DECEMBER 15, 1896.

DR. J. A. FORDYCE, *President, in the Chair.*

A Case of Alopecia Areata.—Presented by DR. S. SHERWELL.

The patient was a married woman, twenty-eight years of age; a native of this country. She had had a number of similar attacks, and had been twice presented to the Society, the last time in April, 1895, when the case was discussed at length. A report of the discussion was published in the *JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES* for October, 1895.

Her present attack commenced about two months ago, when a bald patch made its appearance at the vertex and gradually increased in size. At the time the woman was nursing a child about twelve months old. There never has been a history of syphilis. Dr. Sherwell regarded this as a true case of alopecia areata. The attacks seem to come on when the patient's general health is impaired by lactation, and the condition is probably purely neurotic in origin.

DR. GEORGE T. JACKSON thought the case was undoubtedly one of alopecia areata. He could not agree with Dr. Sherwell's statement that the condition of the scalp was due to an atrophic process. He regarded the latter as one which never recovers its normal state. In this case the appearance was caused by a falling out of the hair-bulbs. It was most likely that the patient would recover perfectly.

DR. A. R. ROBINSON said that while in the main he agreed with Dr. Sherwell, he had not proved his theory of causation. Even if in this case the loss of hair is due to a depraved state of the system, that would hardly prove that the lesion is of neurotic origin. If the term alopecia areata is employed to mean falling out of hair in patches, irrespective of the manner of the falling out, then discussion is useless; but if limited to area Celsi, we recognize only one cause, and the falling out is the result of a local infection by organisms.

DR. G. H. FOX said that vitiligo, which is looked upon as being of neurotic origin, may begin as a small patch and gradually extend at the periphery, and he did not see why a patch of alopecia areata should not do the same. It had always seemed to him that alopecia

areata, like vitiligo, is dependent on some interference with the function of nerves which influence the nutrition of the skin

DR. ROBINSON said he did not see what connection vitiligo had with the subject under discussion, as the cause of vitiligo is not yet decided.

DR. FOX replied that he considered it a fair assumption that the disturbance of the pigment in certain portions of the skin was due to impaired innervation, and he thought the same held good in alopecia areata. In both diseases the patches spread in the same manner.

DR. SHERWELL, in reply to Dr. Jackson, said he did not regard the atrophy of the skin as permanent. There is a general lack of nourishment, which induces more or less atrophy of the tissues. He did not think that the phenomena in this case could be explained on any other assumption than that they were of neurotic origin.

DR. FOX asked Dr. Robinson whether he considered every eruption which spread peripherally as being necessarily parasitic?

DR. ROBINSON said he did not. If these cases of alopecia areata are due to nerve injury, or changes in the nerve, why is it, he asked, that they do not extend further, and why, as a rule, are the lesions confined to parts of the body well supplied with hairs? Given a special kind of ground, this occurrence supports the theory of parasitic origin. In experiments on the subject, he has many times produced bald patches from infection of organism into the scalp.

DR. SHERWELL said he would reply to Dr. Robinson by asking another question. Why is it that the lesions of psoriasis disappear at certain seasons of the year? It would seem as difficult to explain one as the other, to say nothing of the circular, and peripherally spreading lesions of erythema multiforme, psoriasis, and urticaria.

DR. ROBINSON said that he looked upon psoriasis as a parasitic disease.

A Case of Syphilis.—Presented by DR. SHERWELL.

The patient was a man who had already been presented by Dr. Sherwell at a recent meeting of the Society. He had a syphilitic gumma on the forehead, which had been freely cauterized, under the supposition that it was cancerous in its nature. When he came under Dr. Sherwell's observation, all such active measures were discontinued, a mild mercurial ointment was applied and the wound strapped. Under this treatment, and a mild mixed treatment, the wound was almost entirely well.

DR. KLOTZ said that those cases usually yielded very rapidly to active specific treatment, especially if they had not been treated with mercury before at all or not for some time.

DR. FOX said Dr. Sherwell's patient had informed him that the lesion on the forehead had existed for ten years, that it was never "lumpy," and looked like a ringworm at first. He was inclined to believe that the original lesion was a rodent ulcer, belonging to the superficial form of epithelioma, and that the severe cauterization to which the patient had been subjected produced the beneficial effects now observed. It did not seem to be cured now. It was possible

that syphilis might be mixed with it. He suggested that Dr. Sherwell rely entirely upon internal mixed treatment, which would certainly cure it if it was due to syphilis, pure and simple. He was inclined to believe, however, that the lesion was a superficial form of rodent ulcer, and would persist in spite of mixed treatment internally.

DR. S. LUSTGARTEN said he was inclined to look upon the original lesion as a rodent ulcer. The quick change that had taken place for the better while the patient was under Dr. Sherwell's care, pointed to a syphilitic element complicating the original lesion.

DR. SHERWELL said that when this man came under his observation, he put him on mixed treatment, as the diagnosis was not absolutely certain. Externally, he applied a little ichthyol and mild calomel salve, at the same time strapping the wound. Around the ulcer, and separated from it by quite a margin, was a trocha-like elevation, of which a small portion still remains. The man gives a history of syphilis, which he contracted nearly twenty years since. In view of the rapid and steady improvement that had taken place in the lesion since the man had been under his care, the speaker said he was inclined to believe that the original trouble was a serpiginous syphilide which had been treated mistakenly.

DR. KLOTZ said he did not think that the long duration of the lesion could exclude the diagnosis of syphilis. It probably had been one of those slowly progressing serpiginous syphilides which extend over years, and show little or no tendency to ulceration. He was of the opinion that the acute inflammatory conditions and the final rapid breaking down had been due rather to injudicious applications of caustics.

DR. SHERWELL said the elevation encircling the ulcer consisted of soft tissue, which gradually became firmer. Healing has steadily progressed, and up to the present time there has been no further breaking down of the tissues.

DR. FOX said that the form of ulceration seen in this case was common to both rodent ulcer and syphilis. The rapid improvement that had occurred in this instance led him to the belief that the original lesion had been a rodent ulcer which was reduced by cauterization. It is true that a serpiginous syphilide may exist for ten years, but he had never seen it remain localized for so long a period, whereas a rodent ulcer frequently does.

A Case for Diagnosis.—Presented by DR. FOX.

The patient was a woman, fifty years old, a native of Sweden, who came under his observation about two weeks ago. During the past eleven years she had suffered from recurrent suppuration at the ends of the fingers of both hands. At present the nails are about one-half their normal length, and the terminal phalanges are shortened, due to exfoliation of the bone. There is a sclerodermatous condition of the hands and fingers, and the extremities of the latter have a peculiar club-shaped or drum-stick appearance. In cold weather the joints of the hands become stiffened and painful. Pus was found at the ends of some of the fingers. The patient has had

an atrophy of the lower part of the face and is unable to protrude the tongue.

DR. R. W. TAYLOR said that he did not think the case could be classed as one of scleroderma. He had observed the same exsanguinated, eburnated condition of the fingers in Raynaud's disease. It appeared to him that in this case there had been an antecedent condition, whether of the nerves or blood vessels he did not know. He was inclined to think that the case was originally one of Raynaud's disease, which got well after destroying part of the bones and nails. In three cases coming under his observation, similar lesions occurred, the ends of the fingers finally being left rigid, the integument being so hard that the bone underneath could not be felt to be distinct from it. It was unfortunate in this case that a more complete history was not obtainable.

DR. SHERWELL said he agreed with Dr. Taylor. The woman's hands, he thought, presented every evidence of Raynaud's disease. He called attention to the fact that several competent observers have claimed that in every case of Raynaud's disease syphilis had existed.

DR. TAYLOR said that in the case shown by Dr. Fox there was no evidence that there had been an antecedent lardaceous deposit in the fingers, as we see in scleroderma. He could not agree with the statement that Raynaud's disease is more or less etiologically related to syphilis, since he had observed cases of the former disease in which there was no evidence whatever of syphilis. There is an endarteritis and round-cell infiltration surrounding the vessels and nerves. While syphilis may simulate, in its clinical appearances, a case of Raynaud's disease, the speaker said he did not think that all cases of the latter disease were of syphilitic origin.

DR. JACKSON referred to a case of undoubted scleroderma coming under his observation last winter, involving the hands, chest and face, in which the appearance of the hands was exactly similar to that in Dr. Fox's case.

DR. KLOTZ said he had seen three cases which he considered cases of syphilitic endarteritis, with partial gangrene. The fingers were blue, cold, and painful, but there was no swelling and no similarity to the case presented.

DR. LUSTGARTEN regarded the case as one of sclerodactylitis, which is considered a localized scleroderma of the fingers, and is often followed by, or complicated with, similar changes in other parts of the body.

DR. FORDYCE said that this patient certainly presented the clinical appearances of scleroderma. Whether there had been an antecedent Raynaud's disease or not, he could not say. The lardaceous deposit referred to by Dr. Taylor does not necessarily appear in all cases of scleroderma.

DR. FOX said his experience with Raynaud's disease was so limited that he could not say whether such an attack had preceded the present condition or not. He agreed with Dr. Fordyce that the pre-existing lardaceous condition mentioned by Dr. Taylor had been absent in many cases of scleroderma coming under his observation.

He regarded this case as one of scleroderma. The club-shaped condition of the fingers, as well as the shortening, might be attributed to destruction of the ends of the bones, due to the constant pressure of the tightly drawn skin.

DR. H. G. PIFFARD said he thought there was a tendency nowadays to apply the term scleroderma in too comprehensive a sense. He agreed with Dr. Taylor that the term should be confined to those cases that have been preceded by this iardaceous deposit. It is true that the last stage of scleroderma is this hard atrophy, but this also occurs in Raynaud's disease.

DR. FOX said that no matter what the preceding condition may have been, the lesions at the time of observation are similar to those to which the name scleroderma is applied.

DR. PIFFARD said scleroderma is the name applied to a certain disease. According to the definition given by Dr. Fox, however, it simply describes a condition, not a disease.

DR. TAYLOR said that in Raynaud's disease, in syphilitic subjects, we may get a condensation of the tissues, which condition might be termed scleroderma, but this would only give rise to confusion in dermatological nomenclature. In the case shown by Dr. Fox he did not think that the fingers bore any more resemblance to scleroderma, as he had observed that disease, than does a corn.

DR. PIFFARD said a tendency exists among the dermatologists of the present day, when they meet with a case which they cannot exactly classify, to include it under the title of some heretofore sharply defined disease.

DR. TAYLOR said that while he did not favor over-refinement in the classification of diseases, at the same time he was opposed to confusing conditions which are etiologically distinct.

DR. FORDYCE said that most diseases are classified according to their clinical conditions rather than their etiology.

A Case of Acute Lupus Erythematosus.—Presented by DR. LUSTGARTEN for Dr. Bulkley.

The patient was a woman, aged 38, a native of Ireland, occupation housemaid. The disease had begun on the face seven months previous, but had recently developed very rapidly in the scalp and on the back of the hands, and six days previous had invaded the palms. At present the eruption is quite acute, although somewhat cooled down by treatment. The face is almost entirely covered, also the ears, and the backs of the hands and forearms are the seat of acutely developing papules which quickly coalesce into fairly typical patches. Upon the scalp and ears the eruption is very typical, also on some portions of the face. Eight of her family died of tuberculosis. (Note. Soon after her visit she developed double pneumonia of which she died within a week).

DR. LUSTGARTEN regarded the case as one of lupus erythematosus disseminatus, of the subacute type.

DR. FORDYCE said he agreed with Dr. Lustgarten that the case was one of disseminated lupus erythematosus. The speaker said that at the meeting of the American Dermatological Association at

Montreal in 1895 he reported a case of this disease in which the eruption was on the backs of the hands and forearms. The patient was in the second month of pregnancy when the eruption developed. She went on to full term and then had eclampsia. After her pregnancy, the entire process disappeared leaving slight atrophy of the skin. In that case the eruption probably depended on the irritant action of certain toxins, not however of the tubercular variety.

DR. LUSTGARTEN said we should not be too radical in claiming a connection between tuberculosis and lupus erythematosus, as the question is still in doubt. In the last number of the *Archiv* a case of lupus erythematosus disseminatus was reported by Koch in which the *post-mortem* failed to reveal any trace of tuberculosis.

A Case of Nævus Unius Lateris.—Presented by DR. FORDYCE for Dr. P. A. Morrow.

The patient was a young man who had an eruption of several years' duration, which first made its appearance on the middle finger of the left hand, and gradually extended up the inner surface of the hand and forearm, almost to the elbow. It occupied the palmar surface of the middle finger and is prolonged over the palm in the form of a continuous linear band, two centimeters in width. Above the wrist it spreads out to a greater breadth and is made up of slightly scaly papular lesions which are closely aggregated on a reddish base.

DR. JACKSON thought the eruption was of neurotic origin.

DR. ROBINSON said he was not prepared to exclude nævus unilateralis, in spite of the fact that the lesion had partly disappeared.

DR. LUSTGARTEN said he was inclined to regard the case as one of nævus striatus unilateralis. It would be interesting to learn the histological factors in the case. He was of the opinion that similar cases have been reported, also with inflammatory conditions and itching, and undoubtedly of the nature of a nævus.

Cases Previously Exhibited.—DR. FOX reported that his case of pemphigus in a boy had entirely recovered. In his case of leprosy the ulcer on the sole of the woman's foot was nearly healed.

A Case of Congenital Ichthyosis.—Reported by DR. SHERWELL.

The speaker said that in 1894, at a meeting of the Society, he presented a similar case, concerning which he read a paper at the American Dermatological Association, May, 1894—published in September number of the JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES of that year. That infant died at the age of about seven months in summer of same year.

In 1895 the same woman became pregnant, and miscarried nearly at full term, the fetus appearing perfectly normal in all respects, as to skin, etc. In 1896 she became again pregnant and was delivered (the same medical man, Dr. R. A. Black, being always in attendance) of another female ichthyotic infant, which, while not so marked a case, was nearly so. The child was little short of full term, possibly fourteen days. He saw the child by courtesy of the doctor on the 2d day after birth. It died in about a fortnight, a *post-mortem* was held by Dr. Winfield, the most interesting macroscopical discovery being

the total absence of the thyroid gland. Some portions of skin were removed, a portion of which he has, and will be submitted to members of the Society. Dr. Winfield will doubtless also furnish a report.

NEW YORK ACADEMY OF MEDICINE.

SECTION ON GENITO-URINARY SURGERY.

STATED MEETING, TUESDAY EVENING, FEBRUARY 9, 1897.

RAMON GUITERAS, M.D., *Chairman*.

Fibroid Sclerosis of the Corpora Cavernosa.—ROBERT W. TAYLOR, M.D.

DR. TAYLOR presented a case of fibroid sclerosis of the penis. Patient was forty-four years of age, married. Gave no history of syphilis, venereal trouble, or traumatism. When the penis is erect it is bent downwards, and coitus is so unsatisfactory that patient does not indulge in it. The peculiarity of the case is that the trouble is situated on the side and low down, instead of the saddle-shaped condition usually met with on the dorsum.

This affection has heretofore been described under the title of chronic circumscribed inflammation, an obvious misnomer, since no one has ever observed an inflammatory condition connected with it. This affection begins slowly, painlessly, and insidiously, and is first recognized by the patient as a little bean-like lump or plate of tissue in the sheath of the corpora cavernosa, which may be slightly painful on pressure or during erection. As a rule, the sclerosis is tolerably well advanced when the surgeon is consulted, and he finds a firm hard plate of tissue, perhaps the size of one's thumb nail, seated in the superficial portion of the corpora cavernosa. Its margins are usually sharply defined and regular, but there may be exceptionally uneven small nodules and perhaps thickening. The deep parts are, as a rule, free from disease. The induration of the plate is variable; in some cases it is cartilaginous, but usually has a kind of elasticity. As the plates grow old they may become very dense and wholly inelastic.

The lesion may occupy one corpus cavernosum, or both, but it always seems to begin on the dorsum of the penis, particularly near the median line. In general, the plates are found to be of the shape of a saddle, usually symmetrically placed over the cavernous bodies. The smaller plates are ovoid, and they have been found as long as two inches and as small as one-half inch. As a rule this sclerosis attacks the corpora cavernosa, but quite exceptionally it involves the corpus spongiosum.

When both corpora cavernosa are invaded the plates may be firmly united on the dorsum of the penis or they may be separate. In those cases in which the lesion is unilateral this inner edge usually impinges on the median dorsal line of the penis, but, quite exceptionally, there is found a sclerotic plate situated on the side of the cav-

ernous body. As a rule, we find but one saddle-like plate, but in some instances two, one just behind the glans penis, and the other further up the organ. These plates may have their long axis in any direction, but usually it runs antero-posteriorly. This affection interferes more or less with erection according to the size of the plaque. If this is small it may cause but slight distortion of the penis, but as it grows larger it so interferes with the proper erection of the penis that it is bent usually upward and to the affected side, or may be somewhat twisted; exceptionally it is bent almost to a right angle. In most cases the erectile tissues underlying the lesion in the whole length of the organ become hard and firm during erection. When, however, the trabeculated tissue has been attacked by these sclerotic infiltrations, the penis beyond them is not at all congested, while the erection in the proximal part is complete.

This affection is peculiar to those of middle or advanced age. Patients have vague recollection of trauma, but as a rule nothing can be learned from them.

Etiology.—We have no precise knowledge as to the cause of the affection. By some it is thought to be the result of a gouty condition, and by others that it is caused by diabetes. Notwithstanding that Verneuil and Tuffier, in twenty-six cases, found fifteen patients to be gouty and eleven diabetic, it does not follow that these conditions are true etiological factors. In all probability the origin is local, and perhaps the result of traumatism.

Pathology.—According to Tuffier and Leloir these nodules resemble microscopically keloid, there being a fibrous network of tissue like that of scars, with few vessels and embryonic cells showing a tendency to fibrous transformation. In short, the process is a chronic fibroid sclerosis.

Prognosis is very uncertain. There is no case on record in which the sclerosis has disappeared. Patients are usually growing old and no longer eager for sexual activity, and so it is most complacently borne.

Treatment.—Little can be done for this affection. Mercurial unctions, applications of iodine, and the use of the constant current may be tried, together with potassium iodide internally.

Diagnosis.—In the tertiary, and sometimes in the secondary period of syphilis, the erectile tissues of the penis may be attacked by localized gummatous infiltrations. The parts attacked are the corpora cavernosa and the corpus spongiosum. When the corpora cavernosa are attacked usually one of the halves is the seat of the lesion, and very exceptionally both are involved. As a rule, the patient experiences no pain, and he finds by accident a nodule in the meshes of the erectile tissues. These nodules are sharply defined, of round shape and firm consistence, and may even become quite hard. All these lesions run an indolent course, and, as a rule, do not soften and form abscesses. This causes trouble and disquietude in the patient by reason of the curvature of the penis. Thus, interference with coitus may be produced, and in marked cases intromission may be rendered impossible. In the corpora cavernosa the course

is usually an indolent one, and in some cases the lesions soften and are gradually absorbed. In other cases the breaking down of the tissue leads to an abscess which may be slow in healing. In either of these events loss of tissue and curvature of the penis result. If the case be seen early and a vigorous treatment is instituted, these nodules promptly show signs of resolution and may disappear. Syphilitic nodules of the corpus spongiosum run a similar course to those of the cavernous bodies.

In general, the deep-seated nodular condition of syphilitic infiltration in the corpora cavernosa is so well marked that no mistake in diagnosis will occur. When there is a plaque-like infiltration of the theca of the cavernous bodies, the existence of fibroid sclerosis may be suspected, and in cases of doubt we must rely on the history and on the results of antisyphilitic treatment, which is usually promptly curative in specific affections and powerless in others. An active mixed treatment should be administered internally, and mercuric ointments or plasters should be kept over the site of the lesion.

DR. SAMUEL ALEXANDER opened the discussion, and said that in the classical cases of the disease, as in that shown by Dr. Taylor, the disease begins in the middle, as a rule, and grows symmetrically. He thought it a great misfortune that no thorough microscopical examination had been made of these growths in former years. He then reported the details of an interesting case.¹ The tumor was excised, sent to the Carnegie Laboratory, and was reported as a malignant growth (carcinoma). The speaker thought the case was of peculiar interest to us on account of the mistaken diagnosis. The features of the growth were those of the benign type. The case teaches us, too, that we should not be always so emphatic as Dr. Taylor, in saying these growths were never malignant.

He had seen five cases of fibro-sclerosis of the corpora cavernosa; the growths were always bilateral, and quite symmetrical.

DR. GIBSON asked if Dr. Alexander's case might not have been one of endothelioma. Dr. Alexander said that this had been considered in making the diagnosis, and also the question of its being an alveolar sarcoma, but it resembled more the scirrhus of the breast.

The Chairman had found two interesting cases on record, which he briefly described.

DR. JOHNSTON said he had looked carefully over the growth and thought it an endothelioma originating in the cavernous spaces. It may or may not be malignant, and resembles sarcoma rather than carcinoma.

In closing the discussion on his paper, Dr. Taylor thought that if the tumor was of a malignant nature it was very benign in its course, and said that Dr. Alexander's case was the only one of its kind on record.

Exhibition of Kollmann's Urethral Dilator and Kollmann's Urethroscopic Tube.—DR. FERD. C. VALENTINE showed various kinds of dilators that had been used from the earliest days, with the improvements which have since been made.

¹ Will be published later.

Fibroid Sclerosis of the Corpora Cavernosa.—Six cases, reported by DR. ROBERT W. TAYLOR.

CASE I.—Age, fifty-five years, married, had gonorrhea twice; no other venereal trouble. No traumatic history. There is one thin mass, about an inch in diameter, circular in outline, situated on the dorsum of the corpora cavernosa at the junction of the penis with the belly wall. The curvature is downward on erection. It was first noticed about two years ago.

CASE II.—Age, thirty-five years, married, no venereal or traumatic history. On the dorsum of the penis is a thin irregular plate-like mass about one inch in diameter. Slight upward curvature on erection. Mass appeared six months ago.

CASE III.—Age, forty-five years, widower. Has had one attack of gonorrhea and no traumatic history. He never had syphilis. The dorsum of the corpora cavernosa from the glans penis to the belly wall is occupied by a thin plate of sclerotic tissue. He cannot have intercourse, as upon erection the dorsum is in contact with the abdomen. First noticed the growth about six months ago.

CASE IV.—Age, fifty-one years, married. No traumatic or venereal history. At the middle of the dorsum of the penis and extending forward on its sides is a quite thick mass of indurated tissue. He cannot have connection, as upon erection the body of the penis turns up and to the left, while the glans remain in a soft, flabby condition. This has been going on for fourteen months.

CASE V.—Age, forty-five years, married. Had gonorrhea once; no other venereal trouble; no traumatic history. Involving the entire length of the dorsal service of the corpora cavernosa, the growth is a sharply margined and plate-like mass, one-half an inch in width and very thin. The entire organ becomes erect, but curves upward and to the left to such a degree that intercourse is practically impossible. First noticed the trouble one year ago, when the mass was the size of a pea.

CASE VI.—No syphilitic or traumatic history. About one year ago he had pain in the penis, and when examined by a surgeon no tumor could be felt, but the organ curved upward. He has a saddle-like oval, hard plaque, about one inch from the root of the penis. The penis is constricted in erection for two inches at the base, and circumference is much less than at parts beyond, which swell out and become rigid and firm. But as penis is limber at base he can only enter a woman with a capacious and very moist vagina. Attempts to straighten out the organ when erect caused great suffering. Trauma may have been the cause. Iodid of potassium taken in large doses, over a long period of time, caused no change in the lesion.

Selections.

CUTANEOUS DISEASES.

Bronzed Skin in Diabetes and Other Affections. RENDU AND DE MASSARY (*La Presse Médicale*, No. 11, 1897).

The subject of the paper was a man who suddenly developed diabetes, his urine containing 6.5 per cent. of sugar. The skin of his face was brown, uniformly pigmented. The coloring matter was equally distributed over the body. In this case, as in the numerous others reported in the last ten years, gastro-hepatic disturbances were prominent, and in spite of active treatment he died six months from the time of the discovery of his disease. In all the organs examined, liver, pancreas, heart, lung, suprarenal capsule, skin, testicle, kidney, and lymph-nodule, except a voluntary muscle and the semilunar ganglion, pigment deposits were found in the form of granules of a yellow-ocher color. The granules sometimes united into masses. Their histo-chemical reactions were peculiar; they blackened under sulphohydrate of ammonium and stained blue with potassium ferrocyanid, the reaction Kelsch and Kiener give for their "ocher pigment." All the glandular cells of the organism were the seat of a pigmentary degeneration, as well as those of the cardiac muscle. There were no pigment emboli, and none was found in the blood. Although it is of hemoglobinic origin not an ocher granule appeared in the red corpuscles. The lymph carried the fully formed pigment to the nodes. Taking into consideration three facts, the rarity of pigmentary emboli, the constancy of pigmentation in certain organs, such as the glands, to the exclusion of others more richly vascularized, such as the lung, and the peculiarities of the ocher pigment itself, already discussed, and its constant presence in cardiac fibers, only one pathological theory seems to fit the case. This is the theory originally enunciated by Hanot and Chauffard in their initial work on the question, but applied by them only to the liver, viz.: a "pigmentary dysgenesis" of the individual cells. The ferruginous pigment, resulting from a peculiar action exercised by the protoplasm of a glandular element or cardiac cell on hemoglobin, is part of a general cachexia of the organism, whether that cachexia is caused by diabetes, by hepatic disease, or by malaria; in other words, the formation of ocher pigment is one of the modes of cell degeneration, a degeneration itself coincident with a complete decadence of the organism.

LETULLE in the discussion said that by the side of diabetic, malarial, tubercular, cancerous pigmentary cirrhoses, and those of unknown origin, must be placed an alcoholic hypertrophic variety. All pigmentary cachexias are characterized by almost constant material disorders. Three kinds of pigment are known: (1) the ocher-ferruginous, (2) a yellowish-brown found in brown or granulo-pigmen-

tary atrophy, whose ferruginous nature cannot be demonstrated, (3) melanotic pigment, normally elaborated in the rete. They may cooperate to produce the bronzed tint of the skin, but the ocher and yellow-brown are never found in the same cellular protoplasm, except in cardiac fibers. Cells already pigmented are more than apt to exhibit a phagocytic action toward the ochre variety. All the organs except the gastro-intestinal tract, bladder, prostate, and nerve centers, are tattooed. Glands are especially liable to the degeneration. The kidney epithelium remains almost entirely free. Covering epithelium (epidermis, bronchial tubes, and biliary canals) exhibits by its absence of pigment a marked contrast to neighboring structures. Of connective-tissues, the reticular takes up the deposit most readily; the fibrous and lamellar are most respected by it. Connective-tissue cells show a certain individuality; the large cells of bone medulla and spleen pulp are the only cells in these organs showing pigmentation. Chondroblasts are scarcely touched, and osteoblasts are absolutely refractory to the penetration of colored particles. Muscle, except the myocardium, is immune. The ocher pigment, once deposited in the tissues, is most difficult to remove. The epithelial cell, accumulating it in its protoplasm, becomes enfeebled and dies. The granules fall into the lymph channels and are carried by leucocytes to neighboring nodes. There is a gradual extension along the nodes from the umbilicus upward. Those below remain free. The secreting portions of the sweat-glands are filled with pigment, lodged not only in the cells but thrombosed in the lumen of coil. Capillary emboli are very rare.

JANSELMÉ has recently seen two bronzed diabetics. One developed from a lead intoxication, the other from a blow. A complete blood examination in the second case showed a globular anemia (3,379,000 red corpuscles to the c.mm.), and no increase of leucocytes. Coagulability was normal. No pigment could be discovered. So far as now known, bronzed diabetes develops in three stages: (1) destruction of red corpuscles in the parenchymatous capillaries; (2) the pigment, during hemolysis, is carried into the excretory cells and remains in them, none, for example, being found in the bile; (3) sclerosis develops in the organs attacked. If hepatic sclerosis is associated with that of the pancreas, diabetes appears, only an accessory phenomenon. Ocher pigment is produced every time there is a destruction of red corpuscles, either in circulating or extravasated blood. When it is an acute episode, there is paroxysmal hemaglobinuria; when it continues, it determines a sclerogenous process.

HAYEM said that "deglobulization" alone is not sufficient to explain the deposit of ocher pigment. It is necessary to invoke another factor which can be nothing but the action of parenchymata on the red corpuscles. Finally, organs containing ocher pigment are impermeable to X-rays.

J. C. J.

Miliary Tuberculosis of the Skin in the Course of an Acute Generalized Miliary Tuberculosis. O. LEICHTENSTEIN (*Münch. Med. Wochensch.*, 1897, No. 1, p. 1).

The patient, a boy of four, developed first a tuberculosis of the lungs which became generalized and of which he died at the end of six weeks with symptoms of meningitis. In the course of the fourth week there appeared on the face, trunk, and limbs, a discrete papular eruption. The papules were small, hard, red, rounded, or acuminate, and clearly demarcated from the normal skin. They developed by successive outbreaks in three distinct types; after persisting eight to fifteen days they disappeared, desquamating superficially. Occasionally a vesicle formed at the top of the papule which rapidly dried; sometimes, they became pustular. Disappearance of the eruption was always followed by new outbreaks, but more than four to six papules were never seen on the face, six to eight on body and limbs. The pus during life showed the presence of streptococci; at the autopsy, the papules were found to be composed of tubercles, situated in the papillary layer and containing numerous tubercle bacilli.

Acute Pemphigus. GEORGE PERNET and WILLIAM BULLOCK (*Brit. Journ. of Derm.*, vol. viii, Nos. 5 and 6).

The authors, from careful consideration of their case, arrive at these conclusions:

1. There is a group of rare cases of acute bullous eruption, accompanied by severe constitutional symptoms, and generally terminating fatally, which affects butchers.
2. The disease follows a wound of the hand or fingers.
3. It is probably due to a microorganism.
4. Similar cases in persons who come in contact with dead animals, or parts of them. Bacteriological results confirm this, the organism probably being that described by Demme, and later by Claessen. It was found by the authors in an unruptured bulla. The coccus found was not a normal inhabitant of the skin, was neither of the pyogenic cocci, and was pathogenic for guinea-pigs.

Pemphigus Neonatorum. W. PETER (*Berl. klin. Wochensch.*, 1896, p. 124).

The subject was a seven-day-old child, suckled by a mother who was septicemic. Four days later, bullæ appeared on the face and chest, then over the whole body, one-fourth to one inch in diameter. In the mother's milk were found staphylococcus albus, and aureus, and Demme's diplococcus of acute pemphigus. The last was found in the bullæ, and both it and the yellow staphylococcus in the blood of the infant.

Blood Changes in Purpura Hemorrhagica. BENSAUDE (*La Semaine Méd.*, January 20, 1897).

The author confirms Hayem's observation of the absence of retraction of the blood clot, and of the formation of serum in sixteen

cases with large cutaneous ecchymoses. When the hemorrhage is small, this phenomenon is not present. Bensaude has succeeded in producing purpura by injecting the blood of a purpuric patient into animals.

Multiple Skin Gangrene. JANOWSKY and MOUREK (*Arch. für Derm. u. Syph.*, Bd. 35, 1896).

The disease began in the form of red papules surrounded by a red areola, hard and elastic to the touch. They enlarged and, while one would disappear, leaving a pigmented spot, another would become covered in the center with a brown or blackish crust, adherent to the bottom, becoming thicker and darker as time went on. After falling, a deep ulcer, with elevated overhanging walls, was left. When healing took place by granulation, a pigmented spot remained. The authors regard an infection as the cause.

A Nameless Granuloma. TENNESON, LEREDDE, and MARTINET. (*Ann. de Derm. et de Syph.*, L. vii, No. 7, 1896).

The "nameless granuloma" enjoys a variety of appellations scarcely equalled in dermatology. It is Brocq's disseminate folliculitis, Barthélemy's acnitis and folliclis, Fordyce's (described under acne varioliformis) and Pollitzer's hydradenitis suppurativa, Dubreuilh's idrosadenitis, Unna's spiradenitis. The authors set themselves to prove (1) that neither follicles, sebaceous, or sweat glands are the starting-point of the process; (2) that the tumor is a dermic granuloma, which may secondarily invade the glands, but does not begin about them; (3) that the disease in its discrete form is more common than is thought, and develops on a scrofulous soil. They define granuloma as an infectious neoplasm, but failed to find the pathogenic agent. Macroscopically, the description corresponds with that of the cases already published, and need not be reviewed, except to say that if one accepts the authors' definition of scrofula, making it synonymous with "lymphatism," there can be no cavil on the question of the soil in which the disease flourishes.

Epidermic lesions are unimportant. The disease begins in the lowermost layers of the corium, in the region of the sweat glands, and in the subcutaneous fat. The older nodules are composed of cells surrounding a central area of caseous degeneration. At the periphery of the nodule are seen proliferated, fixed cells and lymphocytes. The vessels are constricted and their walls infiltrated. Within is a zone of epithelioid cells and giant cells, some of the latter in process of formation. The central necrosis is the result of thrombosis and obliteration of the vascular channels. In the outer zone, the secretory portion of the sweat duct was normal. When suppuration begins, the tissues of the derma are all involved indifferently. In a second preparation, showing the beginning of the process, were found rounded nodules formed of cells, limited to the neighborhood of the vessels in the lower dermic layers chiefly. The sweat glands and ducts were not altered. The authors think that the gland lesions previously observed are secondary, not initial, and are produced by

granulomata, which invade the whole lower layer of the corium. They are also of the opinion that the giant and epithelioid cells are probably not due to changes in glandular cells. [It is difficult to reconcile these findings with those of Fordyce, Pollitzer, and Unna. Fordyce (*JOURN. OF CUT. AND G.-U. DIS.*, April, 1891) says: "The features were the presence of inflammation at the situation of the coil glands. A sweat duct could frequently be traced from a nodule to the epidermis, surrounded by small round cells. The glands were unaltered. A direct relationship between them and the surrounding inflammation could not be made out," in consequence. Pollitzer pictures the condition in Morrow's "System" (p. 772), and says sweat glands with swollen cells may be seen at the borders of the nodule. Unna ("Histopathology," p. 400) goes even further: "I also agree with Pollitzer and Dubreuilh that the coil epithelium *primarily* shows certain changes which represent, not the result of the cellular infiltration of the surroundings, but its cause, for they frequently precede it." This is corroborative testimony of a kind difficult to controvert on the strength of examination of two cases.]

J. C. J.

Lymphangioma. LESLIE ROBERTS (*Brit. Jour. of Derm.*, vol. viii, No. 8, p. 309).

The first half of the paper is occupied with a description of five cases of the disease, with their histopathology, whose differences may be understood from the titles given them: Hemato-lymphangioma capillare varicosum, 1. cavernosum, involving the derma from papillæ to sweat-glands (Cases II and III); 1. tuberosum circumscriptum, and 1. tuberosum of Pospelow-Van Harlingen. These distinctions are excessively fine.

Part II is given up to general considerations. Only the forms which consist of new vessels are rightly called lymphangiomata; mere expansion of existing vessels constitutes lymphangiectasia. Differentiation is always difficult, often impossible. Wegner recognizes three modes of origin: (1) Dilatation of preëxisting spaces, (2) proliferation of endothelium and formation of new channels (homoplastic neoplasia), (3) transformation of granulation-tissue into lymph spaces (heteroplastic neoplasia). Nasse, Török, and Unna have modified this somewhat, Török claiming that it is an angioplastic process, Unna admitting hyperplasia of endothelium, but denying a new formation of lymph analogous to the growth of blood-vessels in angiomata. Roberts regards capillary and cavernous lymphangiomata as local overgrowths, originating in embryo and, as a rule, independent of the systemic lymphatic circulation. The characteristic features of lymphangioma are best shown by contrast with those of lymphangiectasia. Diurnal changes in volume and color of the vesicles dependent on variations in the lymph-tide in fasting, after food, etc., are found in true lymphangiectasis. This fact demonstrates the connection with the general system, and the impossibility of their having been cut off *in utero*. There is no flow and ebb in lymphangioma. Increased assimilation, with consequent hyperpla-

sia, is generally a consequence of ectasia. Elephantiasis is an exaggerated form. This is rarely found in the tumor form. The proof of the neoplastic nature of cavernous new growths is not easy.

"An obstruction in the pathway of the lymph vessels can never, in itself, produce a lymphangioma, but this obstruction is necessary to account for the dilatation of lymph channels, which accompanies every case of lymphangioma" (Ünna). The venous channels must be obstructed as well, in order to produce ectasia, owing to the communication between the systems. Neoplasia presupposes a third factor, a power of proliferation of endothelium and perithelium. The origin of postnatal tumors must be sought in prenatal lymphatic development; the prenatal aberration may have its origin in the veins, and lymphangioma may be secondary to this.

Lymphangioma. Urticaria Pigmentosa. T. C. GILCHRIST (*Johns Hopkins Hospital Bulletin*, vol. vii, No. 64).

Lymphangioma.—The lesion which began in early infancy consists of a patch on the thigh, composed of three varieties of vesicles: The smallest, of the color of the skin, and difficult of detection; the second, thick-walled, grouped with a warty appearance; the third, hemorrhagic. They consisted not only of dilated, but also hypertrophied lymphatics of the papillary and middle layers of the corium. Inflammatory symptoms were sometimes present, but no mention is made of connective-tissue hyperplasia.

Urticaria Pigmentosa.—The chief interest in this portion of the paper lies in the pathological findings. The eruption consisted of plaques, nodules, vesicles, and pustules, accompanied by factitious urticaria. Both plaques and nodules exhibited pigmentation. A lesion of each variety was excised and examined, as well as wheals produced artificially. In the latter case, this was done first with the normal skin, then with a wheal four minutes, eight, and twenty, after applying the finger-nail. In the plaques and nodules, pigmentation was found in the lower rete layers, its projections had disappeared, and the whole corium was made up of Ehrlich's mast-cells in a connective-tissue framework. The cells contained coarse granules, and in some fatty infiltration appeared. Karyokinetic figures were practically absent. In the normal skin mast-cells were found scattered, and about the vessels in greater numbers than usual. In the four-minute wheal they were decidedly increased about the blood-channels. The other artificial lesions showed a further increase. This is extraordinary, since it is scarcely possible that mast-cells should come from the blood, or that they should proliferate in so short a space of time.

In ordinary factitious urticaria, after two minutes only, Gilchrist has found vascular dilatation, edema of corium, and pigment-cells; polynuclear leucocytes in the small veins; after five minutes, the first signs of leucocytic emigration, and an appearance of mononuclear round cells; after eight minutes, a beginning disintegration of leucocytes, and increase of mononuclear cells; after fifteen, undoubted evidences of inflammation. Emigration of leucocytes and

edema were found in urticaria pigmentosa, facts not admitted by Unna. It is thus shown that wheals are sometimes inflammatory, and the mononuclear cells are increased in number in fifteen minutes, forcing the conclusion that they are lymphocytes. Dr. Welch thinks that urticaria is a toxemia, the toxin being freed in the tissues.

GENITO-URINARY DISEASES.

Contribution to the Diagnosis and Treatment of Tuberculosis of the Prostate. DR. L. CONITZER (*Centrl. f. d. Krankh. d. Harn- und Sexual-Org.*, 1897, p. 14).

The meagreness of our clinical experience in tuberculosis of the prostate and the questions still unsettled as to its symptomology, curability, etc., prompt C. to publish in detail the history of a single case. Tubercular disease of the prostate is of far more frequent occurrence than is generally believed or diagnosed, and in pathological examinations of such affections of the urogenital tract, the prostate has been found to be involved in a high percentage of the cases. Out of 14 cases reported by Simmonds the prostate was involved in 12, and out of 15 cases by V. Kzrywicki, 14 had tuberculosis of the prostate. It is not always easy to tell at the autopsy table which portion of the genital tract was primarily affected, but in the careful study of the cases by Kzrywicki it would seem as if in the cases of tuberculosis of the uro-genital tract the process had its beginning in the prostate, as it was in this organ that apparently the oldest caseous deposits occurred, and spread from that organ as the central point.

According to the pathological anatomy of tuberculosis of the prostate the process in the earliest stages is characterized by the presence of multiple small caseous deposits. These gradually increase in size, and in exceptional cases may become confluent, so that the entire contents of the prostate may form a cheesy mass, more frequently, however, these deposits break down and form abscesses and break into the urethra, bladder, rectum or perineum, leaving fistulous tracts. Of greatest importance however is the danger of the invasion of the bladder by the tubercular process and of an ascending process passing to the ureter and kidneys, and in a smaller number of cases the rapid development from this point of a general miliary tuberculosis, the process too may spread to the seminal vesicles and epididymis.

In the case reported, the patient when admitted to the hospital, had suffered for two years. There was no family history of tuberculosis, nor had the patient had any previous serious illness. The trouble began by difficulty in starting the stream in the act of urination, and there was pain in the bladder neck as the stream passed into the urethra, radiating into the glans. This difficulty increased gradually so that at the end of the first year the patient was catheterized for the first time. After that he at times resorted to hot sitz baths when the stream would not start spontaneously and sometimes was catheterized. Characteristic symptoms of bladder infection set in, cloudy urine and frequent and painful urination, he lost weight

and strength and was obliged to give up work. He had never had previous venereal diseases. In this condition he came under the care of C. General examination negative, urine somewhat cloudy, almost odorless, acid reaction. Sediment by centrifuge showed pus cells, and by straining, bacilli were found. Catheterization showed resistance and marked sensitiveness in the *pars prostatica*. By the rectum, prostate was enlarged, right lobe more than left, surface nodular, indurated in places and very tender to pressure. Cystoscopic examination of bladder showed inflammatory changes and a number of miliary tubercles.

An operative attack was made upon the prostate by the perineal route, a curved incision anterior to the anus and gradually deepened down to the prostate, the finger of operator in the rectum, protecting that organ. A stiff catheter was introduced into bladder and the prostatic urethra opened upon it. Almost the entire right lobe, which was studded throughout with miliary caseous deposits was extirpated, and the left, which seemed to be less involved, was curetted, and a perineal tube was inserted. Drain was removed in four weeks, and the fistula closed rapidly. Patient urinated spontaneously and seldom experienced pain. His bladder was treated for a time by injections of iodoform and glycerin, later of balsam of Peru. He improved and gained in weight.

Two months later he developed an induration in left epididymis, accompanied by pain in both testicles, and the pain on urination returned. He left to take a course of baths elsewhere. In the next three months he gained sixteen pounds in weight, but he had to be repeatedly catheterized, and the urine became cloudy as before. This was improved by one per cent. injections of nitrate of silver. Then blood appeared in the urine.

After this the tubercular process in the epididymis increased, the left seminal vesical became involved. Then the left kidney became enlarged and painful to pressure. Cystoscopic examination showed an increase of the tubercular process in the bladder. He rapidly lost weight and died a year later.

Microscopic examination of the prostate removed by operation showed involvement of all the tissues of the prostate, but it seemed as if the process had begun in the follicles of the prostate.

In reviewing the case C. thinks that we have here a case of primary urogenital tuberculosis which had its beginning in the prostate and seemingly remained localized there for a long time, but at time of admission to hospital the process had extended to the bladder and after marked improvement, following operation upon the primary prostatic foci, spread to ureter and kidney on the one hand, and to seminal vesicle and epididymis on the other, which led to death without there being essential concomitant involvement of the lungs or of general miliary tuberculosis.

As to the etiology nothing certain could be established. There was neither hereditary disposition, nor the possibility of a genital transmission nor a tubercular focus existing elsewhere to account for the origin of the disease.

In some cases a previous gonorrheal infection has been apparently the predisposing cause, this playing not the rôle of a carrier of the infection but rather that of preparing soil leading to a predisposition.

The diagnosis in this case was made before abscess and fistula formations. The symptoms of which the patient complained would lead to the expectation of prostatic difficulty. The very first symptom, especially, was mechanical; difficulty of urination combined with pressure and tenesmus in the rectum and pain radiating into the perineum, increased by walking, and preventing locomotion. Though these symptoms are not confined to this disorder alone, being observed in stone of the bladder, yet when they occur with increasing disturbance of the general well-being, increasing weakness and emaciation, tubercular disease of the prostate should be one of the first things to think of. The sign given by many authors as the first to occur, a muco-purulent discharge from the urethra and blood in the urine, did not occur in this patient.

As regards the study of the objective symptoms C. offers: 1. The painful resistance in the prostatic urethra to catheterization. The cause of this is in the early stages the swelling of the prostate, in the later stages ulcerations in the prostatic urethra.

2. The result of examination of the prostate by the rectum. We can judge less from apparent change in the size, since this differs in individual cases than from the relation of size and form of the lobes to each other. An uneven nodular surface, change in consistence and sensitiveness of different areas points to tubercular condition, and should abscess have formed this gives a characteristic feel.

3. The condition of the urine. This will differ according as the bladder is tuberculous or not. If the former, then the urine is cloudy and contains pus, but is almost always strikingly acid, and to a certain degree this acid reaction of pus-laden urine in spite of catheter infection points to tuberculosis of the urinary tract. The finding of bacilli in the sediment often presents difficulties and is not always successful, so that a negative result of the bacteriological examination does not militate against an otherwise well supported diagnosis.

4. The result of the cystoscopic examination. This is of great importance in every case. We know then whether the bladder is affected and the stage of the affection. Miliary tubercles point to an earlier, ulcerations to a later stage.

The further course of the disease, especially its propagation in the upper urinary tract may be studied by the cystoscope.

If, however, the bladder is not affected, and we have an early stage of primary tuberculosis of the prostate, the diagnosis may be established by the expression of the contents of the prostate (by the rectum) and their bacteriological examination. This, C. believes, would have rendered the diagnosis possible earlier in the case of the patient presented, as he had suffered two years before a proper diagnosis was made.

The prognosis in tuberculosis of the prostate has always been

regarded as unfavorable. Cases occur in which healing takes place contrary to expectation, but this is an exception and cannot be reckoned on, because in a majority of the cases, tubercular disease of the bladder or of the seminal vesicles complicates the condition and offers greater hindrance to therapeutic measures.

Since disease of the seminal vesicles is very frequent and begins very early, it is important to investigate these organs at the same time that the prostate is examined. If they are markedly involved, they feel by rectal palpation like small, wavy, sausage-like cords, as if injected with wax.

Not until this early diagnosis of tubercular prostatitis is more frequently made will the proper method of management be placed on a satisfactory basis. In 1892 Mansedel wrote: "The opportunity for operative attack is given. . . . with the formation of abscess; till now operations are limited almost to the mere treatment of existing fistulæ or the opening of abscesses which threaten to break into the rectum or through the perineum."

C. refers to three cases of Czerny's, in one of which the entire prostate was a cheesy mass; also to one reported by Meyer & Hävel, and ends by quoting the dictum of Guyon, that it is just as necessary, in patients suffering from urinary troubles, to make frequent examinations of the prostate as it is in rheumatism to auscultate the heart.

Air Distension of the Bladder in Suprapubic Cystotomy. DR. F. T. BROWN (*Ann. of Surg.*, 1897, p. 141).

B. makes a strong plea for a more extended use of air for the distension of the bladder in suprapubic cystotomy, as recommended by Bristow and Keen, in place of distention by fluids or the use of the cumbersome Petersen bag, thus doing away also in most instances with the necessity of employing the Trendelenburg posture. The advantages of this method are that the bladder rises more readily by means of air distension, the tendency under fluid distension being for the bladder to sink lower in the pelvis, that it enables us under all circumstances to omit the rectal bag, that it is safer both on account of this, and also, because air being a compressible medium, is not so liable to cause rupture in diseased conditions of the bladder as is a non-compressible fluid medium. Further, upon opening the bladder the wound is not flooded by the contained fluid.

To render this procedure more ready of performance he has seized upon the principle of the bicycle pump, and has devised a small, light double-acting pump connected at its outlet with a small metal cylinder which can be readily packed with sterilized absorbent cotton for filtration of the air. This can be readily attached to the catheter after it has been placed in position.

As a rule, he recommends cutting down to the fascia transversalis before injecting the air, the catheter and pump being ready in position, the pump being laid across the patient's thigh upon a sterilized towel. The bladder is emptied of urine and washed out before attaching the pump. After the first incision, the air is injected, and

the bladder readily rises into the wound and the amount of distension may be readily noted by the eye. The lumen of the catheter may then be closed by an artery clamp, and air may be removed or more injected at the will of the operator.

The pump injects about an ounce at each in and out stroke of the piston.

B. also calls attention to Keen's suggestion of using air for determining rupture of the bladder. Where this is suspected, the catheter is passed and the contents allowed to flow out, then air is pumped in. If there is no rupture a rounded elastic tumor will appear in the hypogastrium, having a tympanic resonance, while if a rupture is present the air will escape into the general peritoneal cavity and distend the entire abdomen.

Should, in the case of an operation, an intra-peritoneal rupture occur on account of a diseased condition of the bladder, there is not so much danger from the escape of air, as there would be from the escape of the contained fluid, probably holding in suspension infectious material.

Comparative Value of Aspiration and the Supra-Pubic Incision in Acute Retention. DR. LEGUEU. (*Ann. d. mal. d. org. gén-urin.*, 1896, p. 963. Second day of meeting of the French Ass'n of Genito-urinary Surgery.)

L. thinks the circumstances under which we are called upon to make a choice between these two methods for the relief of acute retention are exceptional, as only rarely is catheterism rendered impossible. He has had only nine cases in five years. These two resources have their advantages and their drawbacks.

As to aspiration, he has never seen a case followed by infiltration of urine. This may be avoided by using a trocar of small calibre, and on withdrawal first allowing air to enter the receiver and withdrawing the trocar by a quick movement. He thinks the objection that it is a blind method on account of possible danger to peritoneum of not much importance, there being only two or three cases at most in which it was established that the peritoneum was adherent to the symphysis, and in retention, of course, the peritoneum reaches its highest point. The objection that aspiration is purely a palliative measure and gives result for the moment only, he regards as one of its principal advantages. In diminishing the vesical distension the perivesical congestion abates and often some hours after, catheterism previously impossible, may be easily performed.

Supra-pubic incision is not altogether comparable. The future of the patient is not brilliant, and when the bladder is closed he has undergone in the meantime a traumatism, an operation which is not comparable either as to gravity or results with aspiration, therefore, except in bladder infection, when the value of the operation is not to be disputed, it has no immediate parallel with vesical puncture, and should be employed only when the nature of the obstacle or the gravity of the case permits the hope that there is more to be accomplished than emptying the bladder. Each method has its

indications. There are three great causes in which there is a choice, hypertrophy of prostate, strictures, traumatisms.

I. In retention due to prostatic hypertrophy, aspiration seems always indicated when, the urethra being for the moment impassable, there is neither infection nor false passage. After evacuation, the congestion is lessened and it is often possible to practice catheterism, before impossible. Aspiration may be repeated: when we have warded off the immediate and most urgent accidents there will always be time to have recourse later to operation. The latter may be indicated under one of three conditions; when there is a false passage, when infection is present or when, in spite of repeated punctures, the canal remains still impermeable to the catheter.

II. In stricture of the urethra, complicated by acute retention, each procedure has its indications. For stricture of the anterior urethra whether of gonorrheal or traumatic origin, external urethrotomy and resection when necessary is the operation of choice. Aspiration under these conditions is a means of delay only, in order to defer for some hours an operation the necessity for which is not to be disputed. The supra-pubic operation here is never indicated except secondarily, when retrograde catheterism seems necessary, to find the posterior end of the urethra.

In strictures of the posterior urethra, which are always of traumatic origin, we may propose on principle the necessity of a supra-pubic incision to practice retrograde catheterization. In these cases external urethrotomy without a guide is particularly difficult. L., in two such cases, did this operation before having recourse to the perineal cut.

III. In acute retention in consequence of a traumatism of the urethra, a perineal operation at the site of the rupture is the first to be thought of in all cases. If catheterization is impossible we may consider the rupture as complete. We should not await the return of spontaneous urination and the ultimate cicatrization of the urethra, temporizing with repeated aspirations. On the other hand, supra-pubic incision is absolutely useless in the majority of cases; when the rupture occurs in the anterior urethra we can almost always find the posterior end. L., in one case where the urethra was stripped up by a catheter, the laceration being back of the bulb, fearing a long search for the posterior end, did the supra-pubic operation at once and placed a catheter *à demeure*. The case recovered without accident, still he is not convinced of the necessity for the operation.

When the rupture occurs in the posterior urethra, which is the consequence of fracture of the pelvis, then the question of supra-pubic operation is debatable.

DR. VIGNERON agreed with the conclusions formulated by L. In all cases of acute retention in prostatic enlargement he had been able to pass a catheter. Only twice had the first attempt failed even with the stylet, but in each case after the patient was made to get up and walk about a full hour he had succeeded at the second attempt. Twice had he had recourse to aspiration; the first case, aseptic, had

false passages caused by attempts at catheterization; he was aspirated three times in the twenty-four hours, and then urinated spontaneously. The second catheterized himself, was infected, had made a false route; he was aspirated five times in all.

DR. GUIARD, in general, agreed with L. He thought L., like the majority of authors, was inclined to look upon aspiration as more absolutely benign than it is in reality. There are conditions where it may be followed by most serious consequences. He cited a case. A patient in good health, while away from town, was seized with acute retention. A physician, not being able to pass a catheter, aspirated. The patient immediately after took a train for Paris. Immediately after his arrival his physician, after ineffectual efforts to catheterize him, made another aspiration. Some hours after he was able to introduce a catheter, which he left *à demeure*, which, by accident, was displaced and resisted all efforts to replace it. G. was called, and succeeded in introducing the catheter with a stylet. The urine withdrawn was horribly fetid, his condition was grave, he vomited, pulse 150, dyspnea, severe hypogastric pain, meteorism, and died in thirty-six hours. Death being due, according to G., to the escape of urine through a puncture into the peritoneum.

Whether a case is septic or aseptic, aspiration is only of temporary utility; we should, as soon as possible, place a catheter *à demeure*; especially is this necessary in an infected case. It is important not to allow extreme distension of the bladder to reoccur, for the filtration of a single drop of urine into the peritoneal cavity may lead to peritonitis of the gravest character. G. thinks the great majority of physicians have recourse too easily to the trocar, and apparently are ignorant of the catheter, with stylet (*mandrin*) bent or curved, which can often be so easily passed. Only once in fifteen years has G. had recourse to the trocar; he always carries it, but the stylet catheter has always sufficed. In conclusion: (1) Aspiration is inoffensive in aseptic cases; in those which are septic, it may offer grave dangers unless means are taken to prevent extreme distension. (2.) The catheter, with stylet, permits us to enter the bladder in the majority of cases.

DR. ASSAKY would not counsel aspiration where there was a septic condition. The supra-pubic incision gave opportunity for thorough disinfection, and the decongestion arising from the incision of the vesical plexus permitted greater ease of overcoming the urethral obstacle. He thought that the supra-pubic cut was preferable in obese subjects with pendulous abdomen.

DR. TÉDENAT in some cases complicated by false passages, practiced external urethrotomy. He mentioned the case of a patient sixty-five years old, who was in the hospital for two months and was aspirated regularly two or three times in the twenty-four hours. Catheterization finally was successful, and the urine was absolutely clear; the bladder had not been infected. In two cases where the supra-pubic operation had been performed he had observed that the peritoneum was close to the symphysis. Still, in these cases he thought aspiration, under all the aseptic precautions, could be safely performed.

DR JEANNEL cited a case in which the aspirating needle punctured a vein and a large sub-peritoneal hematoma was discovered at autopsy, the patient dying from kidney lesions.

DR CARLIER cited the case of an old prostatic with retention, how set up a gangrenous phlegmon of the penis; he gave up catheterization and performed supra-pubic cystotomy. In a case having numerous false passages, who refused cystotomy, although there was an infected bladder, he performed aspiration with the apparatus of Potain, and washed out the bladder with borated and silver solutions through the canula; this was done sixteen times, then he succeeded in passing the catheter. The bladder had been rendered aseptic.

DR. POUSSON mentioned acute retention in the case of old strictures, or prostatics suffering from acute gonorrhea, or following operation on the ano-genital region. These are largely of a spasmodic order, and in these cases aspiration is justifiable; a single operation, often relieving the spasm.

Items.

PRELIMINARY PROGRAM OF THE TWENTY-FIRST ANNUAL MEETING OF THE AMERICAN DERMATOLOGICAL ASSOCIATION.

To be held at the Arlington Hotel, Washington, D. C., on May 4, 5, and 6, 1897, during the fourth session of the Congress of American Physicians and Surgeons.

Address by the President, Dr. J. C. White of Boston.

General Discussion.—What conditions influence the course of syphilis; (a) the virus, (b) the individual? Dr. R. W. Taylor of New York, will present the question in its adult aspects, Dr. J. N. Hyde of Chicago, in its infantile aspects.

Dr. C. W. Allen of New York: A scale of measurements for the accurate and uniform description of cutaneous lesions, of universal adaptability.

Dr. J. A. Fordyce of New York: (1) Symmetrical atrophy of the skin; report of a case, with colored drawings and microscopical examination. (2) Impetigo herpetiformis or dermatitis herpetiformis? Report of a case, with colored drawings and microscopic examination of the tissue and blood.

Dr. G. H. Fox of New York: On the various forms of pityriasis and their relation to erythema, eczema, and psoriasis.

Dr. J. Grindon of St. Louis: A peculiar affection of the hair follicle.

Dr. T. C. Gilchrist of Baltimore: A series of eleven cases in one family of Porokeratosis (Mibelli) or Hyperkeratosis excentrica (Raspighi), with histological specimens.

Drs. T. C. Gilchrist and W. Royal Stokes of Baltimore: A case of pseudo-tuberculosis of the face, with some experimental observations.

Dr. W. A. Hardaway of St. Louis: (1) Some further observations on electrolysis in diseases of the skin. (2) Clinical notes.

Dr. M. B. Hartzell of Philadelphia: A case of Impetigo herpetiformis.

Dr. J. N. Hyde of Chicago: A contribution to the study of bleeding stigmata.

Dr. H. G. Klotz of New York: Strong solutions of the ichthyol group in acute and chronic inflammatory conditions of the skin.

Dr. D. W. Montgomery of San Francisco: A case of continuous and hereditary shedding of the finger-nails.

Dr. P. A. Morrow of New York: Title to be announced.

Dr. S. Pollitzer of New York: Remarks on the Xanthomata.

Dr. F. J. Shepherd of Montreal: Cases of feigned eruptions.

Dr. A. Van Harlingen of Philadelphia: Report of four cases of hysterical dermatoneurosis.

Dr. J. C. White of Boston: Lymphangioma of labia majora.

Dr. J. M. Winfield of Brooklyn: Contributions to the etiology of congenital ichthyosis.

JOHN T. BOWEN, M.D., Boston, Secretary.

PRELIMINARY PROGRAM OF THE EIGHTH SECTION OF THE TWELFTH INTERNATIONAL CONGRESS OF MEDICINE.

MOSCOW, AUGUST 19-26, 1897.

I. DERMATOLOGY.

Actinomycosis; Primary Tuberculosis of the Skin; Sarcomatosis Cutis; Acanthosis Nigricans; Pathogeny of Alopecia Areata; Blennorrhagic Eruptions; Malarial Eruptions; Mercurial Eruptions; Treatment of Scleroderma; Treatment of Rhinoscleroma.

II. VENEREOLOGY.

1. When should treatment of syphilis by mercury begin? How long should the treatment of syphilis continue? Is it necessary to treat syphilis at the time of the appearance of the accidents of the disease, or is it better to institute treatment outside of these accidents?

2. Modification of the red blood-corpuscles in syphilitics during the condylomatous period.

3. Methods of treatment of syphilis by injections of soluble and insoluble mercurials.

It is requested that those invited to take part in the discussion of these questions indicate their acceptance by May 1st, and forward their choice of subjects by June 1st of the current year.

Papers on these or other subjects intended for the section may be sent to the President for the United States, Dr. P. A. Morrow, 66 West Fortieth street, New York.

PROFESSOR A. POSPELOW, Secretary,
Moscow, Russia.

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Original Communications.

A CASE OF MULTIPLE CIRCUMSCRIBED SCLERODERMA ORIGINATING IN A PATIENT WITH PROGRESSIVE MUSCULAR ATROPHY.

By GEORGE T. ELLIOT, M.D.,

Professor of Dermatology, New York Post-Graduate Medical School; Consulting Dermatologist to St. Luke's Hospital, etc., etc.

J F., widow, age forty-three, German, was seen by me June 28, 1889. She had come to America twenty-one years before. Had always enjoyed good health and had borne one son, now eighteen years of age. On her arrival here she was employed by a butcher, but after a severe cut on the hand she became a seamstress. Fifteen years ago she had to discontinue this occupation, owing to a weakness of the left hand, accompanied by a sensation of cold. Electrical treatment received at the time was not productive of benefit. Five years later the cutaneous lesions began on the upper arms. Subsequently they developed over the shoulders and finally on the back. Their origin, she states, was accompanied by boring pains in the arms, but beyond that her description and memory was obscure and confused. The patient at the time of consultation was a stout, seemingly healthy woman. Her functional health was good, she slept well, but complained of a feeling of lassitude, of excessive perspiration, of a sensation of cold, and also of severe pinching and grinding pains in the back of the neck, along the dorsal portion of the spine, and over the shoulders and extensor aspects of the upper arms. Pressure over the first and seventh dorsal vertebræ was also productive of pain, the patient wincing and crying out when this was done. Marked changes were also noticed in the hands, the

left being especially affected. The abductors and adductors of the left thumb were atrophied to the extent that no movement could be produced, though the terminal phalanx could be slightly flexed. The thenar eminences of both hands were represented by an almost concave surface. The fingers could not be abducted or adducted, but their last two phalanges could be flexed. The hand could be extended, but the wrist could not be flexed, though its rotation was possible.

Abduction and adduction of the right thumb was slightly possible, but its power of flexion was very small, though extension was natural. Excessive pain in the thumb was complained of. The index and little fingers could be adducted and abducted, but the middle and ring fingers could not be. The dorsal surface as well as the thenar eminence of this hand was flattened and the muscles markedly atrophic. The flexor muscles of the left wrist were decidedly atrophied, those of the right not so much. Fibrillar contraction was very apparent. There was no loss of sensation or of touch.

The objective symptoms so far given, though not absolutely in every detail, were sufficiently suggestive of "Progressive Muscular Atrophy" to warrant my referring the patient to a neurologist for an opinion, and she was sent to Dr. M. Allen Starr. He wrote me that the case was "remarkable for the very *slow* progress of the muscular atrophy. I could not make out any definite loss of pain or of temperature senses, and touch seems acute even on the spots of scleroderma, which is rather strange. There is no affection of the pupils, and the knee jerks are not increased." Dr. Starr's opinion that the case was one of progressive muscular atrophy was very important in establishing the fact that this trophoneurosis preceded and coexisted with the cutaneous process for which the patient had consulted me.

The cutaneous manifestations presented by the woman were in all stages and more or less widely distributed over the upper part of the body. They varied in size from a large pea to a silver dollar, some even larger, owing to the fact that several had coalesced together to form patches. In number there were 145 lesions by actual count.

Back.—The entire length of the supraspinous portions of both scapulæ were the seat of lesions—11 on the left, and 12 on the right side. Along the edge of the left trapezius muscle there were 3 lesions, but only 1 on the right side.

From the middle of the infraspinous region of the scapulæ on both sides of the trunk down to the margin of the last rib, the lesions were found to be 45 in number—17 on the left, and 28 on the right side.

They were distributed especially over the fifth, sixth, and seventh intercostal spaces, beginning at the spinal column and ending at about the axillary line. One or two occurred also in other intercostal spaces, but particularly numerous were they in those previously mentioned; they were most variable in size and it was noticeable that they were here arranged in the intercostal spaces in a linear manner, and presented a zosteriform appearance. Only two patches occurred on the anterior portion of the thorax, one on each side, located in the seventh intercostal space.

Arms.—Over both deltoid muscles the lesions were numerous—17 over the right and 14 over the left; there were 2 of large size over the right biceps; 25 lesions were situated over the right, and 9 over the left triceps muscle. Six were noted distributed over the right latissimus dorsi muscle, and 7 over the left. None were found on any other portion of the body.

The majority of the lesions were markedly atrophic, the skin quite thinned and parchment-like, with here and there punctiform depressions suggesting glandular orifices. They were white in color, sharply defined, oval or circular in shape. Where several had occurred close together and had fused, the outline was irregular, polycyclic, but yet sharp. No redness or violaceous border was apparent around them. Some were slightly sunken in appearance, others bulged out a little, suggesting that the atrophied corium was not able to repress the pressure of the fatty tissue below it and that this latter had pushed out the thinned skin covering it. Many of the spots were very sensitive to pressure, the patient wincing when they were touched. None of the atrophic lesions, nor of the more recent ones, were attached to the underlying fasciæ or muscle, the skin everywhere was freely moveable. There were other lesions distributed here and there over the areas mentioned which showed no traces of atrophy. They were of more recent origin, having appeared only a few weeks previously, and they were particularly painful. They were not well defined; were slightly prominent and indurated, smooth on the surface, but markedly white in contrast with the surrounding skin. The induration appeared to include the entire skin. It was not limited by any violaceous or reddish zone. No other symptoms could be observed in connection with the lesions, nor could any change be observed in them while she was under observation, so that their progress to atrophy was undoubtedly very slow. No section of the skin could be obtained. The woman was seen quite frequently for a space of several months. She became progressively weaker, the muscular atrophy increased, and finally stating that the exertion

necessary to come and see me was too great, she ceased her visits. How soon thereafter she died I have been unable to ascertain.

The history of this case is given for the sake of its clinical value, and, therefore, no review of the symptomatology or nature of scleroderma need be undertaken. The disease itself is well known and recognized, while its nature, though conceded to be neurotic, is not in any way clearly demonstrated. It is probably a neurosis, but what the nerve disturbance may be to which it owes its origin and existence is certainly not yet established or definitely known. I would, therefore, only point out those special features noted in this case which appear to be of some interest or importance. Of these, there should be particularly mentioned the "progressive muscular atrophy" which preceded the development of the cutaneous lesions for a period of five years, and which coexisted with them afterward. As far as I have been able to ascertain from literature, the precedence and coexistence of progressive muscular atrophy with circumscribed scleroderma—*morphœa*—has not been noted. Muscular atrophies have been recorded with the diffuse form of scleroderma, and also contractures, mutilations—*sclerodactylia*—osseous, articular, cardiac, pulmonary, renal and other visceral lesions, but in no case, to my knowledge, has the coincidence or coexistence of progressive muscular atrophy and circumscribed scleroderma been observed.

Though interesting, the number of lesions occurring in this patient is yet not of great importance. Their arrangement in a zosteriform manner in the intercostal spaces is also not unique, such distribution having already been recorded, and they have also been seen in the course of other nerves. In the fact, however, that the zosteriform distribution of the patches was bilateral, occurring in the intercostal spaces of both sides of the body, and similar to a double zoster, the case presents a point of interest, as other cases, as far as I know, have been unilateral. There is nothing peculiar in the other symptoms presented by the lesions. The lilac or violet border often noted may be absent; complete or no atrophy may be present and even entire disappearance of the patch may occur; pain on pressure may or may not be complained of, and in these features as well as others essential to the diagnosis, this case was not in any way unusual. That I have designated it as one of "Circumscribed Scleroderma" and not "*Morphœa*" is in accordance with modern opinion, which has discarded the latter term in favor of the former, and regards the process as one form of scleroderma, not as a distinctive disease.

14 West Thirty-third street.

PEMPHIGUS FOLIACEUS OR DERMATITIS HERPETIFORMIS (DUHRING)?

By ANDREW P. BIDDLE, M.D.,

Lecturer on Dermatology and Syphilology, Detroit College of Medicine and the St. Mary's Hospital Clinics; Dermatologist to the Children's Free Hospital.

THE confusion which still exists, in spite of all that has been written on the subject, in the differentiation of the disease known as pemphigus foliaceus, from the various, more or less, allied cutaneous affections now grouped together under the title of dermatitis herpetiformis (Duhring), prompts me to put briefly on record the history of the following case, which has exhibited features peculiar to each disease and has often caused doubt as to its true character.

On the 22d day of April, 1896, I was called in consultation by Dr. Wm. M. Harvey to see A. W., aged twenty-one years. From the latter was elicited the fact that during boyhood he had suffered from what he termed (and probably rightly) salt rheum of the lower extremities; that some three months previously, while sojourning in Chicago, he had a severe attack of what was at the time supposed to be *la grippe*. (The symptoms were probably the malaise, the chilliness, the fever and the other symptoms common to the onslaught of these chronic diseases.) Failing to recover within a few weeks strength sufficient to resume work, he had returned to his home in this city.

Here he was first seen by Dr. Harvey, who, from the appearance of the eruption as it then existed, and especially from the numerous patches on the mucous membrane of the mouth, coupled with a history of recent illicit intercourse, suspected the case to be one of syphilis. This suspicion has latterly been the foundation for treatment, the only course that has given any promise of betterment. I mention this also as a possible etiological factor.

The family history is of rather negative value, except that the general health of the parents is below par, and one of the eight children suffers from a mitral insufficiency.

At the time of my examination the mental and physical depression of the patient was marked; the temperature was 100° F.; the bullous eruption on the mucous membrane of the mouth was significant, and scattered rather profusely over the lower extremities, and sparingly over the trunk were blebs one-eighth to one-half inch in diameter. These blebs were more or less tense, their contents

clear, and they were usually situated on a slightly reddened surface. Itching was already a pronounced symptom.

I then made the diagnosis of pemphigus vulgaris, which was soon changed to that of pemphigus foliaceus. It is a recognized fact that the early symptoms of the latter disease bear a close resemblance, if not a relationship, to those of the former, so much so, that it is authoritatively stated (Kaposi) that the one merges into the other.

Changes soon followed one another in rapid succession. The patient took to his bed and has remained there ever since. Within two to three months the disease reached its height. The bullæ have become flabby; their contents gradually more and more opaque; they rupture easily and exfoliate, leaving a denuded, oozing corium, whose secretion soon dries up into thin crustation; their number is vastly increased. The entire body is involved, but markedly so the finger and toes. The bullæ of the mucous membrane of the mouth are especially large, their contents distinctly firm, causing great dyspnea and dysphagia, at times alarming. The skin is infiltrated, especially that of the face; the nails and hair are decidedly thinned. The itching is intense, scratching irresistible, so that the entire body is thickly covered with excoriations; burning in a slight degree is present. The bullæ extend even to the mucous membrane of the rectum. Speaking is most difficult, the imprints of the teeth upon the raw tongue being especially aggravating; defecation is painful. The patient is unable to stand on account of the bullæ on the soles of the feet, nor to sit by reason of those over the tuberosities of the ischium. Every movement in bed is a torture; the number of ruptured bullæ being especially large on the parts subjected to pressure in the reclining posture, such as the back, shoulders, and buttocks. The clothing adheres to the surface of the skin, its removal causing pain, greater denudation, and bleeding. The mucous and puriform secretions gather and dry about the mucous orifices, especially at the side of the nostrils. Mere existence is a discomfort. The ravages wrought upon the skin by the disease itself and those produced by the patient exhibit almost all the cutaneous lesions, the macular, the papular, the pustular, the bullous, the excoriated, and the crustaceous, indiscriminately commingled. Pigmentation is marked, of a dark-brownish hue; the body presents an anemic, bloated appearance; a distinct, disagreeable odor permeates the room; the bodily temperature is continuously above 101.5° F. The picture, as a whole, is revolting indeed.

On October 7, 1896, I called in consultation my esteemed *confrère*, Professor A. E. Carrier, who suggested to me that the disease might

be Duhring's, a fact that had not escaped my notice. The accompanying photographs (Figs. 1 and 2) represent the state of the disease at this time. The condition of the lower extremities is especially severe.

FIG. 1.



By the time of this writing, the severity of the symptoms has gradually diminished. The temperature still runs from 101.5° to 102° F.; the sense of chilliness during the whole winter has been extreme, requiring the thermometer of the room to register constantly at 80° F. or above. Though there have been remissions in

the violence of the disease, the body has never been free from the formation of new blebs; and the evolution of the latter is more rapid and a number of them has given way to vesicles and pustules. De-

FIG. 2.



glutition is less painful ; defecation more facile ; the movements in the bed are less fatiguing ; the countenance has assumed a more natural expression ; the face no longer shows denuded corium, and is

less tumefied; pigmentation is less intense; the amount of surface involved is decidedly less, the back and abdomen being especially free, but the lesions on the fingers and toes are persistent and severe.

There is no cicatrization nor atrophic change, no ulceration nor deep pustulation having occurred. There has never been any trouble with the eyes or lids. The appetite has always been fairly good, whenever deglutition has been possible.

Thus, the character of the lesions at the outset would suggest pemphigus foliaceus, their multiformity at a later period, Duhring's disease; the severity and chronicity of the malady might be attributes of either.

51 West Fort Street.

THE PATHOLOGY OF LUPUS ERYTHEMATOSUS.¹

By O. H. HOLDER, M.D.,

New York.

LUPUS ERYTHEMATOSUS was the name given by Cazenave in 1851 to a rather rare skin disease on account of its clinical resemblance to lupus vulgaris. It must not be supposed that up to this time this disease was unknown, for a similar condition had been described by Hebra under the name of seborrhea congestiva. This name was subsequently dropped by the head of the Vienna school himself, and the name lupus erythematosus accepted, but the history of the affection up to the present time reveals the fact that this later title is no more appropriate.

Both in the earlier and later years of its development, the pathology of the disease has attracted much attention. Theory after theory has been advanced, but after careful discussion have been found wanting and so discarded, and perhaps it is safe to say no disease has caused more controversy among dermatologists with such unsatisfactory results. While from the beginning, the affection was uniformly classified as a disease of inflammatory nature, the first great dispute arose over the question of the part played by the different elements of the skin from an etiological standpoint. So predominant are the changes in the seborrheal glands in the early lesion, it is not surprising that the older observers look upon them as the probable starting point of the disease. This view has always been associated with the name of Hebra and the Vienna school, and had it not been for the fact that the lesion appeared on the palms, where

¹ Read at the meeting of the Harvard Medical Society of New York City, held January 30, 1897.

the seborrhæal glands are absent, might have remained unmodified. Forced from this position by these cases, Kaposi for many years upheld a similar theory, but it embraced the sweat-glands as well as the seborrhæal.

It was at this time that a new discussion suddenly came up that overshadowed the question of a starting point.

The researches of dermatology which followed the discovery of Koch's bacillus, placed lupus vulgaris in its assured position in pathology as a true tuberculosis of the skin, and at the same time gave to the question of the nature of lupus erythematosus only negative evidence. Up to this time, M. Besnier and the French school had disputed the grounds on which the disease had been separated from lupus. He claimed that nearly all the patients either showed signs of active tuberculosis somewhere in the body or developed it later. Furthermore, lupus was known at times to spring up on the site of the lesions of lupus erythematosus. On this account, and against the general weight of opinion, he considered the prognosis bad, and so it still stands in French text-books. This theory was also strengthened by the clinical observation that few old people were seen who bore the marks of the disease, but was never generally accepted by men out of France. It has given rise to the most bitter dispute connected with the disease, and still remains unsettled, although the present time sees it in a different shape, but more in accordance with the existing knowledge of the disease. To-day, lupus erythematosus must be looked on as a disease whose position in dermatology has been attained solely by the work of clinical observation. In spite of the care and time spent by investigators and writers, there is nothing of rational nature as yet advanced to explain the peculiar evolution of its lesion. Hence, it is not strange that the French school have so persistently refused to abandon their positions in regard to its relationship to tuberculosis, even if the absence of Koch's bacillus in the lesion has to be admitted, and although the majority of dermatologists are unquestionably against them, they are still upheld by a great mass of accumulated clinical evidence. It seems unjust that, driven from the early position taken by M. Besnier, his school should have been forced to explain on some grounds what they claim to be the indirect relationship of the two diseases, or to admit, as their opponents undoubtedly desire, that the double occurrence of the diseases is a mere coincidence. The theory of a tubercular toxin circulating in the blood and acting on the vessel walls locally is by no means satisfactory, as there are plenty of cases which do not show any signs of advanced tuberculosis, and the disease is extremely

rare when compared to the cases of phthisis. This theory was the natural one to advance to reconcile the disease with remote tuberculosis after the attempt to demonstrate the presence of the bacillus in the lesion had failed, and its lack of acceptance must be looked on rather as a result of the unfortunate position of the French school than as a victory for their opponents. The later attempts to bolster up this theory by comparing the disease with the septic erythemata and classifying it under the name of an angioneurosis have only made their position slightly more firm, but much more complicated and unassailable, and there is little chance of reaching any common ground when both parties admit the same precedents but draw different conclusions. Unfortunate as it is for pathology, the name lupus is shared by the two diseases, and although attempts have been made to change it, it still remains to mask the clinical resemblance.

Although the microscope has not done anything for bacteriology except in a negative way, it has done much in establishing the probable seat of the origin of the disease in the corium. All observers agree that the earliest manifestation is an infiltration of round cells in the middle or lower zones, the changes in the sebaceous gland, which were once considered of extreme etiological importance, being now regarded as a secondary atrophy.

The round cells lie for the most part along the vessels and have no tendency to group as in lupus. They show signs of fatty and granular degeneration to a more or less marked degree, but the peculiarity of this degeneration is that it never attacks the cells *en masse*, but seem to pick them out here and there at random. As far as I am aware but little attention has been paid to the vessels. The fact that many are engorged with red corpuscles and that in places hemorrhages have been noted, seems to be a constant observation, but no emphasis is anywhere laid on the condition of the interior of the vessels. Through the kindness of Professor J. A. Fordyce, I have had an opportunity to examine a larger number of sections taken from a case of lupus erythematosus of the scalp; and it is from these sections that the accompanying photographs are produced.

In places, the vessels show a granular detritus filling the lumen, and continuous with mononuclear leucocytes, packed rather closely together, and giving the appearances of endothelial budding. In other places masses of shriveled-up red blood-corpuscles could be distinctly made out, but this does not show well in the photographs. In the engorged vessels, although the field often was of large extent, there was a great scarcity of leucocytes, although many surrounded the vessels. Hemorrhages in this case were absent, and many of the

new-formed vessels were collapsed and empty. The observation has been made that the infiltration was extremely dense at the bifurcation of the vessels, but this could not be verified, although the walls of certain vessels markedly diverged before entering a mass of round cells, when they became lost for a ways, but seemed to appear again farther out in the field.

While I cannot say that thrombi in the fine vessels are constant in lupus erythematosus, their presence in the only two specimens that I have had an opportunity to examine, taken in connection with what has already been found by microscopists, seems to be worthy of the most careful thought and consideration. The physical effects of thrombi in arteries and veins has been pretty clearly defined, but the process in vessels small enough to allow under pressure, the free escape of serum and white blood-corpuscles, has not attracted sufficient attention. The partial occlusion would be of little importance, but if the entire lumen were blocked, the collateral capillaries would be forced to carry the entire supply of blood coming to the part, and would unquestionably be under higher pressure than normal. Although a more rapid current might in part compensate for this increase of pressure, there would have to be also a certain degree of dilatation of these free capillaries with the discharge of serum and leucocytes into the lymph spaces along the vessels. Instead of their causing any decrease of the supply of nutrition to the adjacent tissue, there would be an increase of fluid in the lymph channels, which would become more and more dilated as the process advanced. The marked increase in the number and size of the lymph channels in lupus erythematosus, has already been described by Unna in his "Histo-Pathology of the Skin." To this condition he gives the name of "central canalization," and considered one of the most important features of the disease, clinically as well as pathologically. That these dilatations are formed merely at the expense of the breaking of cellular areas as he claims, cannot be correct, however, but must be due to an increased tension in the lymph vessels themselves, otherwise their walls would collapse from the normal tension of the tissue around them.

Another important point for consideration is the manner of extension of these thrombi. It is self-evident that progress toward or into the veins is impossible, but upward into the arterial system, while possible, would be extremely slow and could only occur after the current had been retarded by the invasion of a considerable portion of a system of capillaries. The great tendency of the thrombi would be to move laterally through the capillary net-work and to

shut off more and more of the blood as the current became adjusted to the change. It is to this fact that the central atrophy of lupus erythematosus can be rationally ascribed.

Now, how far does the clinical side of lupus erythematosus tally with such an hypothesis? The two conditions necessary for thrombus formation in large vessels are the slowing of the current and some damage to the vessel-wall. A third predisposing cause is the tendency to thrombosis from an altered condition of the blood, seen principally in sepsis, of which the best example is phlegmasia dolens. Although the modern view of this disease holds that it is of septic origin, the advancing thrombosis is not the seat of germs, but of a collection of leucocytes whose tendency to degenerate is probably

FIG. 3.

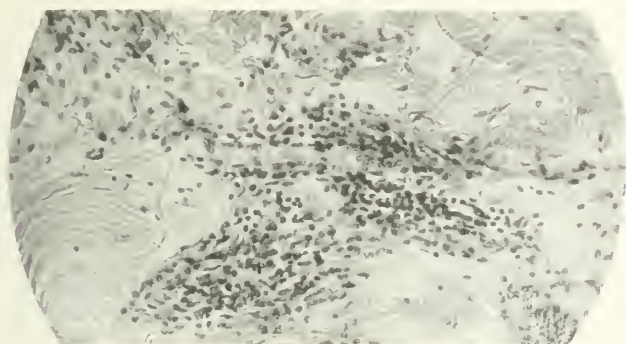


PHOTO. I.—Lupus erythematosus. Scalp. Hematoxylin. Taken from advancing margin of disease; shows granular thrombus in capillary, and perivascular infiltration. Spencer $\frac{1}{4}$ in. Ocular 4 compensation. $\times 300$.

increased by the chemical action of the absorbed toxins. It is quite rational that here is a similar connecting link between lupus erythematosus and tuberculosis in those cases which the tuberculosis is remote from the lesion of the disease, while in those cases in which this lupus develops on the site of lupus erythematosus, it is fair to accede that it is the altered and degenerating protoplasm which affords a condition suitable for the growth of the bacillus. Aside from this disease, lupus erythematosus is most obscure from an etiological standpoint. It has been known to follow frost-bite, and it is here that marked circulatory disturbances can be traced. Not only is damage to the vessel-wall likely, but the subsequent hyperemia would afford slow-running currents. The predominance of the disease in adult life is well marked, but it must be remembered that

during childhood chronic changes in the vessels are extremely rare, if we except the specific inflammation of syphilis and tuberculosis.

The favorite site of the lesion on the face has already been spoken of by writers as pointing directly to the vascular nature of the disease. The preexisting state of rosacea and an open-air life have both been given as predisposing causes, and are of much value to this hypothesis. For the permanent changes in the caliber of the

FIG. 4.

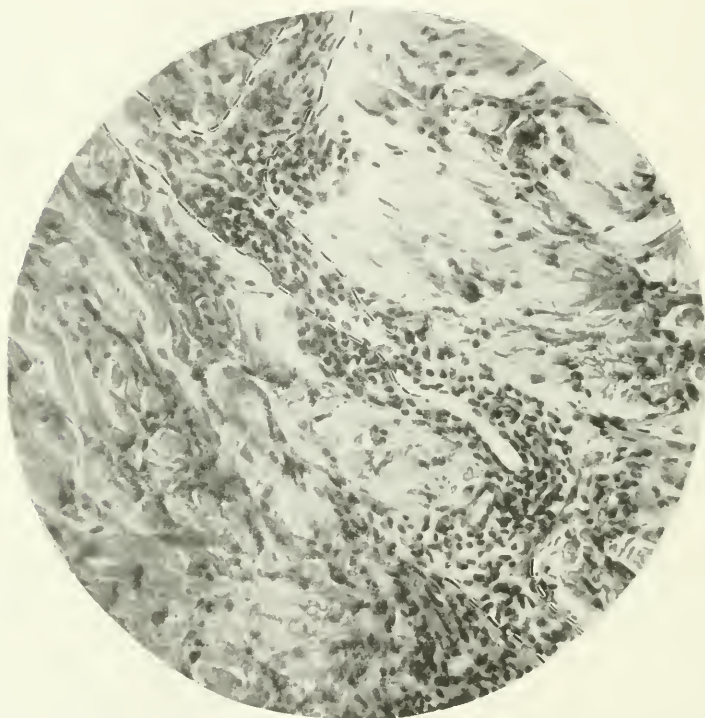


PHOTO. II.—Lupus erythematosus. Scalp. Hematoxylin. Taken from advancing margin and shows at the right lower corner a bifurcation in which the lower vessels are occluded and its walls diverging. The upper vessels were packed with leucocytes in its fresh portion and patent below. Spencer $\frac{1}{4}$ in. Ocular $1\frac{1}{4}$. $\times 200$.

vessels due to the constant dilatation and contraction from heat and cold must have an effect on the rate of the blood current.

It is when we pass to a close examination of the lesion itself that we find most to support the theory of thrombosis. The capricious and slow extension is most characteristic of this disease, and in this lies the main difference between it and other peripherally extending dermatoses. The chronicity alone seems to throw out for considera-

tion any foreign agent as a cause. It is true that lupus involves the skin at an equally slow rate, but it does so by the establishment of new foci and not by peripheral extension.

In this connection also comes up the question of the formation of satellites in lupus erythematosus, but their presence is not against the theory, as it is possible that they are of embolic origin from a thrombus which has invaded a small artery.

The peculiar persistent hyperemia has already been explained on the grounds of an increased pressure, and to the same cause must the dilated capillaries, so often seen branching out from the lesion, be due. The central atrophy has also been mentioned earlier in the paper. While I have treated the entire subject of lupus erythematosus as a whole and have not recognized the subdivision into which

FIG. 5.

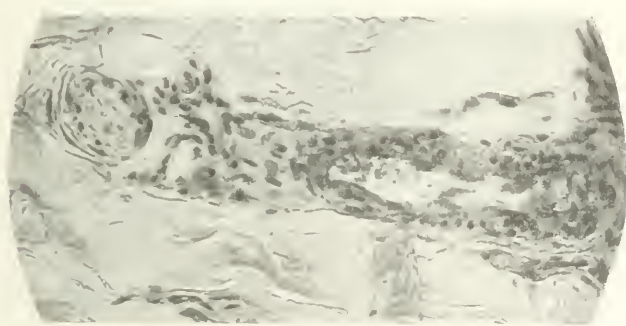


PHOTO. III.—Lupus erythematosus. Scalp. Hematoxylin. Shows longitudinal and horizontal cut of fine vessel taken from atrophic side of the peripheral margin. Thrombi clearly shown; no perivascular infiltration. Spencer $\frac{1}{4}$ in. Ocular 2 P. $\times 250$.

the disease has of late been separated, there is one class of which I wish to speak, as it seems to me that it bears directly on the hypothesis. These cases are those reported by Kaposi, in which the onset of the disease is accompanied by fever, headache, and general symptoms, and which are followed by a fatal termination, the autopsy showing metastatic involvement of other organs.

So clearly do these cases coincide with the present view of pyemic embolism in connection with the septic softening of large thrombi, I cannot but feel that the two processes are identical.

The main object of this paper is to elicit further observation directed along the line indicated, with the hope of ascertaining whether the thrombi are constant or not in all cases, but in summing up once more and briefly, the writer would desire to lay emphasis on

the physical effects of capillary occlusion on the blood-pressure, and its subsequent results on the white corpuscles and the lymph channels. It is not intended that the thrombi should be considered of

FIG. 6.

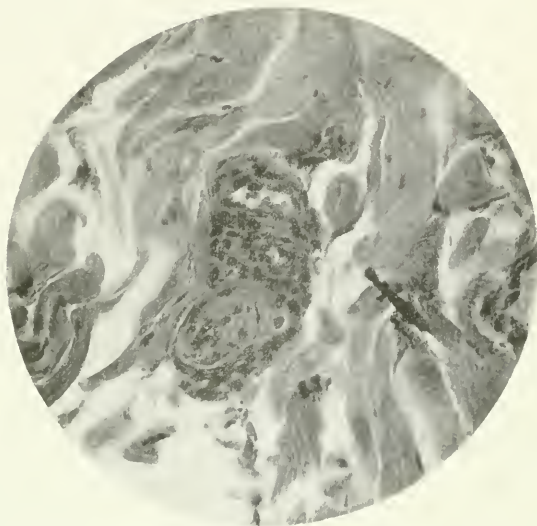


PHOTO. IV.—Lupus erythematosus. Scalp. Hematoxylin. Cross cut of vessel from atrophic portion. The walls are much thickened and the lumen of vessel above occluded. Spencer $\frac{1}{4}$ in. Ocular projection 2. $\times 250$.

primary importance to the origin of lupus erythematosus, but that their existence should be regarded rather as a phenomenon, intermediate between the disease and a dyscrasia of the blood, in which the tendency of the leucocytes to degenerate is increased.

Clinical Notes.

A GROOVED PERINEAL GUIDE.¹

BY RAMON GUITERAS, M.D., New York.

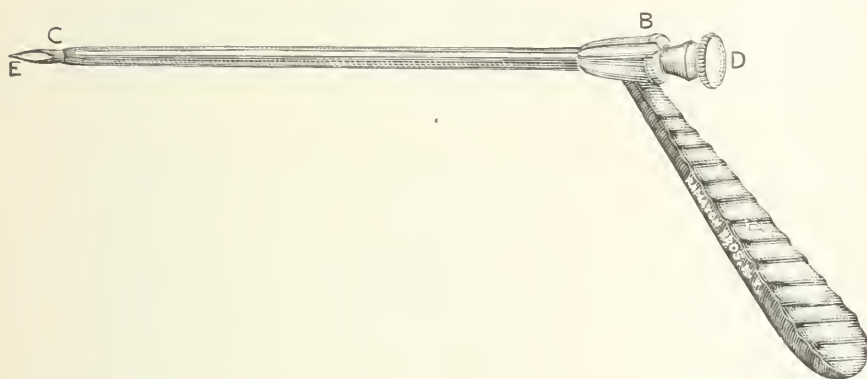
The instrument that I present to you this evening was devised by me, with the object of facilitating an entrance into the prostatic urethra, or neck of the bladder, in cases of impassable deep strictures, and of demonstrating, by means of a guide, the exact route to follow with the knife.

In other words, it is to suggest a method of performing a perineal

¹Presented before the Genito-Urinary Section of the New York Academy of Medicine at the November Meeting, 1896.

section on a guide, instead of doing a Cock's operation. This instrument is shaped something like a Teale's probe gorget, the handle being the same, while the shaft is much smaller and, instead of being a half cylinder, it is a complete one, with a groove on top, that is to say, a canula through which passes a piece of steel, sharp at one end. This forms the point of the instrument, and is enlarged and rounded at the other end to prevent it from slipping through the canula. The instrument may, perhaps, be better described as one composed of two parts—a canula, with a handle attached, and a trochar. On the upper surface of the canula externally is a groove, along which the blade of a knife can be passed into the bladder.

FIG. 7.



The dimensions of the instrument are as follows: The handle is $2\frac{1}{2}$ inches long, the canula is $3\frac{1}{4}$ inches in length, and the trochar $3\frac{3}{4}$ inches.

The method of using the instrument is this: A patient with an impassable stricture and a bladder distended with urine is placed in the lithotomy position. The forefinger of the left hand is introduced into the rectum until its tip is lodged at the apex of the prostate. The instrument is then grasped by its handle with the right hand, and its point is made to enter the median line of the perineum about half an inch in front of the anus, and is then pushed up in the direction of the apex of the prostate gland, until it is felt to pass the end of the finger in the rectum, which is pressing on the gland at that point. It is then probable that its end is in the prostatic urethra, and in order to ascertain whether such is the case or not, while the instrument is held in place, an assistant withdraws the trochar. If urine escapes through the canula it is certain that it has entered the posterior urethra.

If it does not escape the trochar should be replaced, and the instrument pushed a little further in the same direction, when the trochar should be again withdrawn, and so on until the end of the canula is in the posterior urethra behind the stricture, as is evidenced by the escape of urine through it. The blade of a knife should then be run along the upper surface of the canula, with its back in the groove, until the posterior urethra has been opened behind the obstruction. The remainder of the steps of the operation are the same as in Cock's, that is, introducing a grooved director into the bladder, enlarging the incision, and passing in a large catheter, or tube, through the perineal opening for bladder drainage, and fastening it in. Such an instrument simplifies very much a perineal section, and does away with the repeated stabs in the dark, which often do not open the posterior urethra, and only succeed in giving rise to an abundant hemorrhage, which obscures the field of operation.

23 West Fifty-third street, New York City.

INTERESTING OBSERVATIONS IN A SYPHILITIC FAMILY.¹

By LEON L. SOLOMON, A.B., M.D.,

Assistant in Chemistry and Clinical Assistant Department of Pediatrics, Kentucky School of Medicine; Curator Louisville City Hospital; Lecturer on Materia Medica, Louisville Training School for Nurses.

SOME weeks ago, the mother, Mrs. B., colored, brought to the dispensary, Department for Children, Kentucky School of Medicine, her five-months-old boy baby. An examination of the infant revealed the following condition:

About each malar prominence, and extending inward to the nose and upward to the margin of the lower eyelid, was a papulo-squamous circinate eruption, whose center seemed flattened in contradistinction to the periphery, which was distinctly elevated. The area on either side involved by this eruption was not covered by a single lesion, but by an aggregation of annular patches, which had coalesced to form a peculiar but wonderfully exact figure—in fact, as perfect in its outline and contour as if drawn there by the artist's pencil. The condition, I repeat, was bilateral and symmetrical, one side corresponding almost, if not exactly, to the other in its geometrical outlines. There was but one diagnosis to make when the individual annular lesions were sought out and the symmetrical distribution of the eruption was considered; yet, I am free to confess there was some-

¹ Reported by permission of Professor Samuel E. Woody.

thing in its appearance which was not characteristic of syphilis, and rather suggested a tinea infection. However, this idea was immediately abandoned when the history was brought out. The mother, who is better than the average of her race in intelligence, gave this account of the baby and of her family. She states that the baby has had a similar "breaking out" on various parts of the body at different times since shortly after its birth. As a rule, the "breaking out" was on the soles of the feet and in the palms of the hands. She sought medical attention from various sources, and with very good results, so far as the particular attack was concerned; but that there would be a continual reappearance of it in some other locality, until with the appearance of the present manifestations, she became alarmed on account of the baby's eyes. She declared that she had only noticed the eruption on the cheeks for about thirty-six to forty-eight hours. Closer inspection of the patient did not reveal involvement of other localities, and the hands and feet were now quite clean.

The case was a fairly well nourished mulatto child, with regular features and a normal anatomical make-up, but with an appearance which was at once striking, namely, precocious development. There was not that shriveled and senile appearance which we at times find in marasmus, and which is more often observed in cholera infantum, but the skin of the face was dry and somewhat wrinkled. Physical examination revealed a slight bronchitis, decided "sniffles" and hoarseness, a normal heart action, a large liver, and a large spleen. The baby took the breast well, had no digestive disturbance, and the intestinal action seemed good. There was no temperature elevation. Urine analysis was not made. The family history is as follows: The mother said that she had borne eleven children at full term, and latterly (within the last four years) had had three miscarriages. Of the eleven children, seven had died during the first few months of their lives; in fact, none of the seven had lived to reach the age of three months. All had had eruptions resembling that of the baby, and all had had the "sniffles" and a hoarse cry. Of the four remaining children, who were alive, two had had the eruption and other manifestations of the disease. The mother states that they were weak and frail until they were past two years old, since which time they have been hale and hearty. The third of the four had always been healthy, and had never shown evidences of any trouble, either directly after birth or at the present time. This third individual of our interesting family is a boy fourteen years old, the first child. Not satisfied with this re-

port of the other three living children, I requested Mrs. B. to bring her children along with her for the next regular clinic day, which she willingly agreed to do. On this occasion, Wednesday, January 20, 1897, mother and four children made their appearance, were carefully examined, and presented before the class at the Kentucky School of Medicine by Professor Woody. As the mother stated, we found evidences of hereditary syphilis in the two younger children, a girl eight and a half years old and one five. Both have Hutchinson teeth, and the bridge of the nose was fairly characteristic. The eyes were not the seat of disease, nor was there any suspicion of impending keratitis. There was found general glandular enlargement, but nowhere marked. The eldest boy, already referred to, and who, it was claimed by the mother, had always been free from any evidences of infection, had no visible evidences, as he appeared before us, except it be the nose, whose shape was at least suggestive, and the irregular teeth.

The fact of the many deaths—seven in infancy—from what was most certainly in each case hereditary syphilis, and the three abortions of which the mother gives account; the fact that two children were able to withstand the ravages of the disease, while another infant now has it and will probably succumb; and that the first child, a youth now fourteen years old, seemed to escape infection, are all interesting points for our consideration. The mother was closely questioned and as carefully examined. She shows no evidences of ever having had any of the manifestations of syphilis, and denies having had any—no initial lesion, no eruption, no glandular swelling, no loss of hair, sore throat, sore mouth, etc. The father, we have, as yet, been unable to see, but hope to have him come before us. He, however, is undoubtedly the subject of acquired syphilis, which Mrs. B. describes to our satisfaction. In conclusion, I wish to emphasize several salient points by asking as many questions:

I. Was the father the subject of syphilis when the first impregnation occurred, and did the eldest child escape the disease through accident or because the mother was healthy? (The history does not reveal when the father became infected.)

II. If the first child is healthy, does it necessarily prove that the father was later inoculated with syphilis?

III. Is it to be assumed that the first child is healthy, since he has never shown any cutaneous or other lesions, or shall we declare that the appearance of the nose and teeth is absolute proof that he, too, has hereditary trouble?

IV. Is the mother syphilitic, though she has shown no signs (cutaneous, glandular, or other), save the three abortions?

V. Is the mother immune?

VI. If the mother is immune, would it not, nevertheless, be unwise to permit her to nurse in other families? I ask this last question because I desire especially to emphasize the fact that I found the mother was acting as wet-nurse and, I might add, wet-nursing in a very prominent family, who, for some reason, were anxious to keep this fact a profound secret. Of course, I ordered her to cease giving the breast save to her own baby. How any physician could make the selection of a wet-nurse in this case without eliciting a history that would make him fearful—at least suspicious—is a puzzle for me.

Mrs. B. says she begins to menstruate immediately after the cessation of lactation, and usually becomes pregnant at once, rarely seeing a second menstrual period. I hope to keep the family under observation, and by treating both sides of the house, have her give birth to a healthy child the next time.

323 West Walnut street.

NON-VENEREAL SYPHILIS.¹

By HENRY ALFRED ROBBINS, M.D.,

Washington, D. C.

ON October 5, 1896, a colored girl, aged twenty years, presented herself for treatment at the South Washington Free Dispensary. A little to the right of the median line of the upper lip there was a rounded, tumor-like infiltration, with a scarcely appreciable induration. The whole lip was puffed out, showing the pink, rose-tinge of the mucous membrane, contrasting vividly with the ebony hue of the girl's complexion. The sublingual, post-cervical, axillary, and epitrochlear glands, were enlarged and as hard as pebbles. All over the abdomen there was a maculated erythema. She complained of nocturnal headache and rheumatic pains. There was no evidence of an initial lesion of syphilis on the external organs of generation.

The girl stated that her uncle had a sore mouth and that her lip became sore in July, and that she first imagined it was a "fever blister," but now she thought it came from drinking from the same glass that he used. Dr. James T. Arwine, who is connected with

¹ Read before the Medical Society of the District of Columbia.

our dispensary service, visited the home of the patient and found that the uncle of the girl was employed by Dr. Phillip B. Brooks, who kindly gave the following notes relating to the uncle, which substantiates the truthfulness of the unfortunate girl's statement.

On the prepuce of the uncle there was a cartilage-like induration and situated above Poupart's ligament there was a bubo. There was a papulo-pustular syphiloderma over the face, around the mouth, and over various parts of the body, and in the mouth were mucous patches. On the day of the girl's first visit (October 5th) she was placed on $\frac{1}{4}$ of a grain doses of the proto-iodid of mercury, and the lesion was soaked in black wash several times a day.

FIG. 8.



The excellent photograph which is now before you for examination was taken on October 10th by an amateur artist, a friend of Dr. Arwine. It is an exact representation of the lesion as it was on that date. One week later there was a most marked improvement in the girl's condition. The chancre was very much reduced in size, the mucous membrane of the lip not being visible, and the inflamed lymphatic glands were smaller and softer.

A few months ago a young colored girl reported at our dispensary (South Washington) carrying in her arms a white infant. In the girl's mouth were mucous patches. In Vienna she would have been arrested and sent to a hospital, where she could be treated by

competent physicians, and prevented from carrying the disease to the family circle where she was employed. We could only threaten to inform on her unless she immediately gave up her place.

Several years ago I called attention to similar facts in THE JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES, in relation to colored waiters carrying syphilis in the mucus patches of their mouths, who migrate every summer to our mountain and seaside resorts.

On October 22, 1896, a colored child, aged nine years, was brought to the South Washington Free Dispensary by her mother. Around the vulva, seated on the labia majora, which was edematous, there were a number of condylomata of the moist variety. There was a slight oozing of a mucus discharge at the posterior commissure. There was enlargement of the inguinal and epitrochlear glands. Over the abdomen there was a macular erythema, and there was a sort of exaggeration of the natural pigmentation of the skin, that I have but very seldom observed. There was no evidence of either parent ever having had syphilis. The child, as they informed us, was healthy at birth. It never had the "snuffles." There was no arrest of development, no evidence of having had "interstitial keratitis," no "otorrhea," no "Hutchinson's teeth," and, in my opinion, the patient was not suffering from *syphilis hereditaria tarda*.

No initial lesion was discovered, but when you find an edema of the labia majora, you may be almost certain, that there is a hidden chancre. The tender age of the child prevented a thorough examination. The lesion may have been concealed behind the fourchette. The adenitis was well marked—this follows a chancre, as Ricord said, "as the trunk follows the root of a tree." As to how the disease was imparted we are in doubt. It may have been through the medium of a towel or rag, or it may have been caused by dalliance with an evil-minded believer of "voodooism." Dr. Arwine, my friend and colaborer at the South Washington Dispensary, tells me that among certain of the degraded poor it is the belief that if one of them gets the pox he can rid himself of it by giving it to a child.

On the same day, October 22d, a colored female child of the same age (nine years) as the one already reported, was brought to our dispensary (South Washington). At each of the commissures of the lips there was a fissure, with enlargement of the sublingual and post-cervical glands. Over the pectoral muscles there were patches of almost faded-out roseola. As far as Dr. Arwine and I could ascertain, there was no history of syphilis in either parent, and they

stated that the child had always enjoyed perfect health. There did not exist any evidence of the "triology" of Hutchinson's marks of hereditary syphilis, viz., "interstitial keratitis, defective incisors, and otorrhea;" nor did there exist the other two which Dr. F. R. Sturgis of New York, has proposed to add to the "triology," that is, "no general congenital atrophy, and no general arrest of development." It is true that the fissure at the commissures of the lips did not present the appearance of the initial lesion of syphilis in regard to infiltration and induration, but for many years I have given more weight, in diagnosing syphilis, to inflammation of the lymphatic glands than to the appearance of the primary sclerosis. As to how the child acquired the disease, I would answer—just as any member of this society might accidentally acquire it, by drinking from the same glass of water, that has been polluted by one who has a buccal mucous patch. These syphilitic germ-carriers are not confined to the lower classes.

Dr. A. A. Hoelling, Medical Director, U. S. Navy, permits me to report to the Society two cases of non-venereal syphilis, which have come under his observation:

"I have met with two cases of true chancre, followed by constitutional symptoms, in which the initial lesion was not the result of the sexual act. The first case presented a chancre on his right index finger, followed by a bubo in the corresponding axilla, and later by a foul ozena.

"The second patient had a chancre at the lower surface of the scrotum, due to wearing a pair of unclean drawers, which he had purchased from a sailor infected with the disease."

Some few months ago, in getting material for a revised edition of "unmerited syphilis," I wrote to my friend, Dr. Irving C. Rosse, Member of the Royal Geographical Society, who is so well known as an expert authority on mental diseases. The Doctor, most kindly, sent me the following, which occurred during his service as a medical officer of the United States Army:

"When on duty at Fort Monroe, Virginia, I was consulted one morning at sick-call by a Sergeant of Artillery, who showed a sore on his wrist, which he said came from a slight scratch that would not get well. From its indurated edges, and other characteristic appearances, I immediately recognized the sore as syphilitic, but on questioning the Sergeant, a man of excellent reputation, he stoutly denied ever having had any venereal complaint. The sore remaining indolent for some time, despite local treatment, I again told the Sergeant my suspicions, which were met with the former protesta-

tions of innocence. Further inquiry into his personal habits showed that he and a member of his battery, lately discharged from hospital with syphilitic sores on the hands and feet, were in the habit of *using the same sponge, towels, and wash-bowl.*

"In the course of time, constitutional infection followed the sore, for which treatment became necessary. The Sergeant ultimately made a good recovery; at last accounts he was Master-at-Arms on board a naval flagship."

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

TWO HUNDRED AND FIFTY-EIGHTH REGULAR MEETING, HELD ON
TUESDAY EVENING, JANUARY 26, 1897.

DR. J. A. FORDYCE, *President, in the Chair.*

A Case for Diagnosis.—Presented by DR. C. W. CUTLER.

The patient was a woman who had enjoyed perfect health until about the middle of November, 1896. She then had an eruption break out over the right shoulder-blade. The lesions are all alike in character, one-third of an inch in diameter, and have been confined strictly to the scapular region. They number about thirty, and are rounded in shape, presenting a central necrosis and a well-defined outline separated from the normal skin by a distinct line of demarcation. The lesions are discrete showing no tendency to run together. As the slough separates a clear, well-defined ulcer remains which heals readily leaving a smooth white scar. The lesions are not present in all stages of development. The woman is an Italian, and it is impossible to get much of a history from her.

DR. A. R. ROBINSON expressed the opinion that the eruption was an artificial one. DRS. ELLIOT and SHERWELL were of the same opinion.

DR. G. H. FOX said that some time ago he saw a very similar case. His patient was a strong, healthy man, with apparently no neurotic tendencies. The eruption was directly over the spine, and consisted of about a dozen lesions, the larger ones covered by crusts, with smaller ones at the periphery. His patient declared that the lesions were of spontaneous origin.

DR. R. W. TAYLOR said that the lesions were very similar in appearance to those produced by injections of the bichlorid of mercury. Following such injections the skin may become red, then a little boggy, followed by the formation of a dry eschar which sloughs off, leaving a sharply marked cicatrix.

DR. CUTLER, in closing the discussion, said he was inclined to agree with the general opinion expressed that the lesions were pro-

duced either by the patient herself, or by some one else. The eruption commenced in November, a new lesion appearing every two or three days until some time in December; since then no new lesions have appeared. They are gradually healing, leaving a sharply defined scar. They were probably the result of some caustic application or hypodermic injection. When the woman first came under observation, small red points were noticed in the affected region which seemed to be due to the introduction of a hypodermic needle.

A Case of Idiopathic Multiple Pigmented Sarcoma of the Kaposi Type.—Presented by DR. G. T. JACKSON.

The patient was a French Canadian, forty-eight years of age. The disease had lasted about twenty-one years. It affected the hands, forearms, feet, legs, and the region just above the thighs. It began on the fingers and toes and had been slowly progressive, though the man's general health seemed to be good. During the past year many of the lesions on the hands have disappeared. A number of tumors had disappeared before from the face and ears. He took Fowler's solution of arsenic in increasing doses for four months, apparently with some benefit. For the past four months he has been taking some herb preparation, a secret remedy of some one in his neighborhood, and this has, he believes, done him a great deal of good. Dr. Jackson said that this case would be reported in full, together with a pathological report by Dr. Elliot, at the next meeting of the American Dermatological Association.

DR. CUTLER thought it was remarkable that the case had existed for so long a period without causing death and without further extension.

DR. GEORGE T. ELLIOT said he thought that other cases of pigmented sarcoma on record had existed as long as this one. The pathological formation was very interesting, the angiomatous condition of the lesions being quite well marked. The case might be really termed a mixed-cell pigmented angiosarcoma. Some of these cases have improved under arsenic, others have not.

DR. FORDYCE said the prognosis in this form of sarcoma seems to be better than in some of the other varieties. Hardaway reported a case where recovery took place after fifteen years, and Brayton of Indianapolis, a case which had existed over twenty years. In a patient of his own the angiomatous element referred to by Dr. Elliot was very well marked.

DR. ELLIOT asked Dr. Bronson what had become of his case.

DR. BRONSON replied that the patient had suffered intensely up to the very day of his death, which was due to exhaustion.

DR. ELLIOT said that in Dr. Bronson's case he had found that there was beginning sarcomatous infiltration about the nerve trunks. This probably gave rise to the severe pain from which he had suffered.

DR. FORDYCE said it appeared to him that the etiology in this form of sarcoma must be entirely different from that of other varieties. There seems to be a general blood infection, as the tumors develop

simultaneously in different parts of the body independently of a primary growth.

DR. SHERWELL said that one of the cases he had reported recovered under arsenic. That case probably belonged to this same variety of angiosarcoma.

A Case of Recurrent Erythematous Eruption Accompanying the Removal of Tubercular Glands in the Neck.—Presented by DR. E. B. BRONSON.

The patient was a woman who had already been presented by Dr. Bronson several months ago. For a number of years she had suffered from tubercular glands in the neck, for the removal of which several operations have been performed. The eruption recurs when there is a recrudescence of the diseased glands, and rapidly disappears after their removal, under very simple treatment. The eruption most commonly affects the face but has occurred on other parts of the body; the lesions are dusky red in color, with more or less infiltration, sharply circumscribed, and in size vary from miliary to macular. Some of them are simply red and scaly, while others have gone on to pustulation. There is no subsequent atrophy of the skin, though where the disease has existed and healed there is ischemia most marked when the face has been exposed to cold or heat, when such places appear white in contrast to the surrounding skin.

DR. ROBINSON said he was inclined to believe that the eruption was the result of some form of toxemia. He had a piece of one of the glands removed from arm and neck, but had not yet had time to examine them.

DR. ELLIOT regarded the eruption as of toxic origin. It might be called a toxic erythema of some sort or other, and was probably directly connected with the process in the glands of the neck.

DR. JACKSON said the case was somewhat similar to the one he presented at the last meeting of the Society, where there was a well-marked eruption of lupus erythematosus on the face accompanying the development of tubercular glands in the neck; the glands were excised and then lupus vulgaris developed.

DR. BRONSON, in closing the discussion, said that when this case was first presented to the Society, it was suggested that it might be a lupus erythematosus, and he was not at first inclined to that opinion. When the patient first came under his observation, the lesions of the skin together with marked adenopathies were believed to be syphilitic. They bore a decided resemblance to a tuberculo-pustular syphilide. There was also, except in this location, some resemblance to the erythema induratum scrofulosorum of Bazin. The ischemia left by the disease might represent an incipient condition of atrophy which does not become pronounced as in lupus erythematosus generally because of the comparatively short duration of the lesions.

A Case of Multiple Epithelioma.—Presented by DR. C. W. ALLEN, to show the result of treatment.

This patient had been presented by Dr. Allen at the last meeting but one. At that time there was a large epitheliomatous ulcer on

the left side of his nose, which was being treated with pyrogallol. This treatment was continued, in spite of the unfavorable opinions as to the result expressed by several of the members at that time. At the present time the lesion on the nose is entirely healed with a soft cicatrix and shows no evidence of disease. The two smaller lesions on the cheeks disappeared a month ago under the applications, and during this time no applications have been made to the cicatrix upon the nose.

DR. JACKSON said he did not think the case could be looked upon as cured. It is true that it had been healed over, but this occurs not infrequently in these cases, and the chances were that it would break down again.

DR. FOX said that while this case certainly showed the good effects of pyrogallic acid, he thought the use of the curette would have been a more speedy and efficient method of treatment. Formerly he used the curette and then applied the pyrogallic acid to the raw surface, but latterly he has discarded the acid entirely, simply using the curette very thoroughly. If a nodule does reappear it can be readily destroyed by boring into it with a dental burr dipped in carbolic acid.

DR. SHERWELL said that while he did not regard Dr. Allen's patient as entirely cured, yet he might remain well for a long time. Dr. Allen was certainly to be congratulated on getting so good a result in a patient so advanced in years.

DR. ROBINSON said he did not congratulate Dr. Allen on the result at all. He did not think the result was a good one, and a much better one might have been obtained in less time by other means. He decidedly objected to the use of the curette or carbolic acid alone. Such treatment is wrong in principle and theory. The infection is usually deep, far beyond the reach of these agents. One application of arsenious acid paste in a case of this kind would have almost certainly effected a rapid and complete cure.

DR. BRONSON said that while the result obtained by Dr. Allen was apparently very good, it could hardly be regarded as brilliant and he did not think a permanent cure had been effected. In persons of advanced age, with epithelioma, it is comparatively easy to secure cicatrization. When the part of the lesion infected with pus germs is removed it is very simple to make the ulcer heal over, but in almost all such cases there is a recurrence.

DR. ELLIOT inquired of Dr. Robinson whether he thought there was nothing to be done with epitheliomata except to treat them with arsenious acid, and whether that agent always produces a permanent cure.

DR. ROBINSON replied that he regarded arsenious acid as the very best application in a case of this character. It would, with almost absolute certainty, have produced excellent results, both as regards the permanency of the cure and the amount of deformity following the treatment.

DR. ELLIOT said he had seen cases of epithelioma, very marked, which were permanently cured by means of curetting and the subse-

quent application of pyrogallio acid. He had also seen cases, very superficial in character, which relapsed after the application of arsenious acid. He had seen cases relapse after the use of the red-hot iron. The most certain and thorough method, in his opinion, was the surgical treatment: cutting well beyond the site of the lesion.

Dr. ROBINSON said that the views expressed by Dr. Elliot were purely a matter of opinion. They were entirely at variance with his own clinical experience.

Dr. FOX said he had used the arsenic paste in many cases of this character, often with excellent results. In a case like the one shown by Dr. Allen he thought the curette used with vigor would remove the morbid tissue more quickly and produce less pain and better cicatrization than any other plan of treatment. He had seen many cases relapse after the use of the knife.

Dr. SHAWWALT said that many cases of this character have come under his care, and for some years he has confined himself largely to one method of treatment, which had given him excellent results. The treatment he referred to was the thorough use of the curette, followed by an application of the acid nitrate of mercury.

Dr. ALLEN, in closing the discussion, said that while he usually employed the arsenious acid paste, he had regarded this as a favorable case for the use of pyrogallol. He did not see any necessity for the use of the curette, as there was an open lesion at the time of observation, and he relied upon the "searching-out" qualities of the pyrogallol to destroy the more deeply seated epitheliomatous tissue. It apparently had done excellent work in this instance. The border of the wound feels quite supple and there is at present no evidence of cancerous infiltration. He did not think the use of the knife would have been advisable in this case, nor would it have given as good final results. He would report subsequently upon the patient's condition. In the continued presence of the dirtiness and the local seborrhoeal lesions new lesions might readily develop anywhere upon the face.

A Case of Nail Disease for Diagnosis.—Dr. H. G. KROUT presented the patient, whose case he had mentioned at the last meeting as bearing a certain resemblance to a case then presented by Dr. FOX. He was a man thirty-one years of age, an Austrian Hebrew by birth, fourteen years in the United States, a life insurance agent who had never done much manual labor. He stated that he had always enjoyed good health and was feeling perfectly well now, except for the condition of his hands. About five years ago he noticed discoloration of the nails on both hands; about three years ago the ends of the fingers began to swell, and gradually attained the condition which he presented when first seen about six weeks ago.

The distal phalanges of all the fingers are more or less increased in volume and are held in flexion at an angle of about 133° . The nails had lost their natural smoothness, luster, and color, but were less affected at the proximal ends, where even a lunula could still be recognized. Toward the distal end they became more rough, had lost their transparency, and showed a yellowish-gray color, while the

free margins were of a more decidedly yellow color, thickened, brittle, and partly broken off. The bed of the nails was somewhat thickened in the distal portion. The entire soft parts of the third and part of the second phalanx were thickened, the skin bluish-red, distended, and on some fingers perfectly smooth and shiny.

The fingers occasionally pained spontaneously, but were always very sensitive on being touched, so that the use of the hands are greatly impaired. The nails of the toes were similarly, but slightly affected. There was no indication of any disease of the nervous centers; knee and other reflexes were normal.

The condition of the fingers had greatly improved since under the local application of a ten-per-cent. salicylic-acid plaster and arsenic internally.

DR. BRONSON said he regarded the condition as a tropho-neurosis. Dr. Allen also expressed the opinion that the condition was of nervous origin.

DR. KLOTZ, in closing the discussion, said he agreed with Drs. Bronson and Allen that the condition was probably of neurotic origin. Still there was a possibility that the condition was partly due to the presence of a slow-working parasite, the appearance of the breaking down of the nails at the distal extremity suggesting such an origin.

A Case for Diagnosis.—Presented by DR. GEORGE T. ELLIOT.

The patient was a man who five months ago developed an eruption over the scalp, face, and arms. In many respects the case corresponded to some of those reported as universal acne varioliformis, etc. On the face there was a strong resemblance to a small papular syphilide, and he had so regarded the case until he had examined the entire body. On the face some of the lesions in color and character looked strikingly like those seen in lupus follicularis. The speaker said that a case reported by Dr. Bronson some years ago, seemed to him to resemble this case.

DR. ALLEN said he did not think the case corresponded at all to one of acne varioliformis, as he had observed the latter condition, with its peculiar central necrosis, depression, or "mortised-in" crust.

DR. R. W. TAYLOR said that in his opinion the case was undoubtedly one of syphilis. There was a general adenitis, which was particularly marked in the inguinal regions. It was quite possible that the primary lesion was of an ephemeral nature and had escaped notice. He regarded the eruption as a typical example of the larger form of the small, miliary papular syphilide.

DR. JAMES C. JOHNSTON said he was inclined to regard this as belonging to the group of cases which have been described by Barthelémy as acnitis and folliclis, by Dubreuilh as hydrosadenitis, by Politzer as hydradenitis, and recently by Tenneson and Leredde under the title of "a nameless granuloma," a cognomen bearing greater relation to the present state of knowledge than any of the others. In those cases the microscope showed a purely inflammatory (granulo-

matous) condition of the derma and subcutaneous tissue, oftenest localized about the coil-glands.

DR. BRONSON regarded the case as an anomalous one, bearing a closer resemblance to *acne varioliformis* than to anything else. In many respects the case differed from the one which he had presented some years ago. The lesions in this case seem to be more deeply seated, and there is a distinct infiltration, due apparently to granulation tissue. In his own case the lesions were very superficial and there was a slight exudation which formed a dry scalp. The lesions in Dr. Elliot's case certainly looked like syphilis.

DR. FOX said that clinically this case resembled those which he presented to the Society under the name of colloid milium. In his cases the lesions were somewhat larger, and the arms were not affected. They were hard to the touch, and in some respects resembled a papular syphilide. He did not think that the eruption in Dr. Elliot's case was syphilitic in character.

DR. ROBINSON said he did not think the case was one of syphilis. Neither did he regard it as an anomalous case of *acne varioliformis*, for the reason that there were so many lesions, yet none of them were characteristic of *acne varioliformis*. He thought the lesions were the result of a follicular infection.

DR. FORDYCE said he did not think the case resembled the one shown by Dr. Bronson some time ago. In that case the evolution of the lesions was very rapid and they disappeared quickly, leaving scars, many of which had a central slough.

DR. ELLIOT said he presented the case as an anomalous one, corresponding possibly to some described as *acne varioliformis*. When he first saw the patient he thought the case was one of syphilis, but closer observation led him to discard that diagnosis. It struck him as being one of those cases which are the result of an infectious process connected with the sweat glands; the lesions are inflammatory, run a slow course, and leave pits and scars which are first pigmented and then become perfectly white. Dr. Elliot said he would leave the diagnosis open until he had had an opportunity to examine some of the lesions under the microscope. He did not think that the case bore any resemblance to the cases of colloid milium shown by Dr. Fox, excepting in the color of the lesions.

A Case of Seborrheal Eczema.—Presented by DR. A. R. ROBINSON.

The patient was a man, forty-one years of age; a coachman by occupation. The eruption had existed four weeks. There was no history of any previous attack. Dr. Robinson said that some of the members would call the case one of psoriasis, which it very much resembled.

DR. ALLEN said he thought the case was one of seborrheal eczema and not of psoriasis, although it resembled the latter.

DR. BRONSON said the case appeared to him to be one of psoriasis rather than seborrheal eczema.

DR. FOX said he did not think the case was one of psoriasis, nor

was it a true eczema, although it would be generally classed under the name of seborrheal eczema.

DR. ELLIOT did not consider the case one of seborrheic dermatitis, and thought the condition was more closely allied to psoriasis than to eczema. The diagnosis in these cases was largely a matter of individual opinion. The eruption, while it had some of the features of both psoriasis and seborrheal eczema, was, in his view, absolutely independent of both, and really of unknown character.

DR. ROBINSON, in closing the discussion, said that in the main he agreed with Dr. Elliot. While cases of this kind are usually classed under the name of seborrheal eczema, yet he did not think they were caused by the same agent as that which produces the ordinary form of seborrheal eczema. Properly speaking, it was a psoriatic form of eczema; it certainly was not the ordinary psoriasis, or the ordinary seborrheal eczema.

Symmetrical Cutaneous Atrophy.—Presented by DR. J. A. FORDYCE.

E. E., female, aged forty. A native of Sweden. Married; no children. The patient is nervous, easily fatigued, and subject to frequent attacks of mental depression. Marked tremor of the hands is present at times. Her present trouble is of two-years' duration. The dorsum of the left hand was first involved, followed by a similar trouble about the left foot and ankle. The right lower extremity was soon implicated in much the same manner as the left. Irregularly rounded patches appeared on both lower extremities and over the extensor surfaces of both knees. The extensor surface of the left elbow was affected in the same manner. There were a few small spots on the face, which have disappeared, leaving little trace of their former presence.

The first pathological condition seems to be a capillary dilatation, followed by desquamation and subsequent atrophy; the atrophy follows the zone of dilated capillaries. The skin about both ankles is purplish-red, atrophic, and covered with scales. The lower extremities are at times exceedingly painful and swollen, so that locomotion is difficult. A number of outbreaks of bullæ about the ankles have occurred. The diseased areas on the legs are painful on pressure. Over the dorsum of the left hand, where the atrophy is most pronounced, there is little desquamation and no abnormal sensibility. The atrophy here extends from the terminal phalanges some distance above the wrist, the skin having a wrinkled, parchment-like appearance. In color, the diseased areas are purplish to brownish-red, the tint almost completely disappearing on pressure. Some patches of permanent pigmentation are to be seen, especially above the left elbow.

DR. JOSEPH COLLINS, who kindly examined the patient in reference to her nervous system, was unable to find anything that pointed to a spinal or peripheral nerve lesion. He detected a difference of the surface temperature on the two sides, the thermometer in the left axilla registering 100° , that in the right, 99.5° F.

DR. KLOTZ said he thought the case bore some resemblance to

lupus erpthematosus. The lesions on the arms did not seem to be the same as those on the legs.

A Case of Keratosis Pilaris.—Presented by DR. FOX.

The speaker said that the case appeared to be one of ordinary keratosis pilaris, with this peculiarity, namely, that upon the upper extremities the eruption was more marked on the flexor aspects than upon the extensor, as is usually the case.

DR. ALLEN said he would not call it a case of keratosis pilaris, but he thought the term "lichen" more applicable, although he did not care to venture a positive diagnosis.

DR. BRONSON thought the case resembled Crocker's description of lichen pilaris.

DR. JACKSON said that he did not know what to call it. It somewhat resembled the lichen pilaris of Crocker and it also resembled keratosis pilaris, though it occurred in the wrong locations for that disease, and was inflammatory.

DR. KLOTZ called attention to the inflammatory nature of the process, which we would not expect in a keratosis.

DR. FOX, in closing the discussion, said he thought the eruption was primarily a follicular one, but whether the inflammation was an essential feature of the disease, or whether it was secondary to a blocking up of the follicles, was a question which was still to be decided. He was particularly interested in the peculiar localization of the eruption upon the flexor aspect of the arms.

A Case of Syphilis.—Presented by DR. TAYLOR.

The patient was a man forty-five years of age, who seventeen years ago had a chancre which was hard. Four years ago he had another sore on the penis which he thinks was not hard. He does not remember ever having any secondary symptoms, excepting that his hair fell out about eighteen months ago, and that he had rheumatoid pain.

At the present time he has had general ganglionic enlargement. He has also had an eruption on the forehead, and a peculiar, sharply defined, very superficial brown scaling lesion on the penis. He has been actively treated with mercury, almost to the point of salivation. Dr. Taylor said that the man had just then presented himself and was very anxious to know whether he had syphilis, which he had assured him he had. He would like the opinion of the whole Society.

DR. ROBINSON thought the lesion on the penis was para-syphilitic in character, occurring late in the course of the disease, and in a patient with some dyscrasia. Though these lesions are usually called syphilitic, there is no organic syphilis to account for them. They are probably the result of some irritation, which gives rise to a peculiar inflammatory process in a tissue changed by a previous infection by syphilis.

DR. FOX regarded the lesion on the penis as a syphilitic patch, serpiginous in form.

DR. BRONSON regarded the lesion on the penis as a tubercular syphilide of the late stage. In reply to Dr. Robinson, the speaker said that his statement might just as well be applied to all the later

lesions of syphilis. Most of these are irritative manifestations; gummata very commonly are.

DR. KLOTZ said he was particularly interested in Dr. Taylor's case, because he had seen a number of similar ones which had puzzled him in regard to a diagnosis, and which proved very obstinate to treatment. From his experience he would not regard these lesions as syphilitic in character. He observed them on persons who had never had syphilis, and he had not seen them affected by specific treatment, even where syphilis was manifestly present. The lesions sometimes suggested lupus, sometimes lupus erythematosus; in other cases, lichen planus, psoriasis, or even ringworm. They yielded sometimes to strong antiparasitic treatment. In the last case, which came under his observation about one year ago, he removed them with liquor potassi in a short time.

DR. ALLEN said he also regarded the lesion on the penis as a late syphilitic manifestation. He would not regard it as para-syphilitic until he had tried a very thorough course of local and general specific treatment. He pronounced the lesion a late tubercular, squamous syphilide.

THE NEW YORK ACADEMY OF MEDICINE.

SECTION ON GENITO-URINARY SURGERY.

STATED MEETING, TUESDAY EVENING, MARCH 9, 1897, AT 8.15 O'CLOCK.

RAMON GUIERAS, M.D., *Chairman*.

Sclerosis of Testis and Epididymitis with Hydrocele in a Syphilitic.—DR. HERMANN G. KLOTZ presented specimens from the case.

The patient from whom the specimens were taken was twenty-eight years of age, had a chancre in 1889, and had several recurrences, which disappeared under anti-syphilitic treatment. He first saw the patient in 1893, who said that he had received a severe squeezing of the scrotum. He found a swelling of the testicle, with increased consistency, but not very painful on pressure. The epididymis was not affected. Mercurial plaster and iodid of potassium did not improve the condition very perceptibly. Five months later the testicle was of normal size and consistency, except in the lower portion, which was still hard. In August, 1896, a small, irregular tumor, which was quite hard, could be felt at the lower part of the epididymis. Treatment did not seem to be of much benefit.

He saw the patient again in January, 1897, when he found enlargement of the left side of the scrotum, with distinct fluctuation. He aspirated a clear, deep-yellow hydrocele fluid. The testicle was twice its normal size, with no change in its shape. The epididymis was enlarged, particularly in its longitudinal direction. Both were abnormally hard and firm.

The diseased organs were removed January 15, 1897. The tunica vaginalis was thickened. The testicle presented a perfectly smooth surface. The head of the epididymis was separated from the lower

end of the testicle, and of the size of a large cherry. On section the large part of the tumor was found to be formed by one large node. Both epididymes were covered by a thin layer of grayish tissue of a glossy, cartilaginous appearance. Similar sclerotic tissue in the form of bands and irregular patches were distributed through both organs. Interposed between this cartilaginous tissue there appeared patches of various sizes, of a yellowish, opaque, fine, and almost structureless tissue, which has the appearance of cheesy matter, but is very elastic to the touch.

The speaker thought that the peculiar cartilaginous, almost transparent tissue, and the nearly cheesy, but firm and elastic, yellowish, and opaque tissue, pointed to the syphilitic nature of the process.

Under the microscope, besides the absence of all characteristic signs of tuberculosis, marked endarteritis as well as specific changes of the connective tissue lead to the same conclusion.

DR. TAYLOR thought the case certainly looked like those cases of tubercular infiltration, becoming later the seat of syphilitic infiltration.

DR. KLOTZ had suspected tuberculosis. There was no fever, and under the microscope no indication of tubercular tissue.

A Case of Hematocele.—DR. GUITERAS presented a man, twenty-eight years of age, who had had two or three attacks of urethritis without any complications. Two years ago he was kicked in the scrotum, from which time the scrotum slowly enlarged, and the testicle on the left side became hard and tense. There was evidently fluid in the tunica vaginalis, although there was no translucency on observation. The cord above the ring was normal. Diagnosis of hematocele was made, and an operation done.

An incision was made into the tunica vaginalis. Following the incision, a port-wine colored fluid and a substance resembling coffee grounds escaped. The epididymis was found to be enlarged and indurated. An incision was made through the tunica albuginea, which revealed some pathological changes going on in the lobes of the testes. The question arose, Was it a syphilitic testicle, a chronic epididymitis, or a tubercular testicle? The patient had given no history of syphilis, nor could evidence of it be found before the operation. There was no history of epididymitis or orchitis of gonorrheal origin. It therefore seemed probable that it was a case of tubercular orcho-epididymitis, and the testicle was removed.

DR. FRANK FERGUSON examined the tumor microscopically, and pronounced it a tubercular testicle.

A Case of Urinary Extravasation.—DR. GUITERAS presented a second case. A man, thirty-two years of age, with a congenital hypospadias, had been suffering from retention of urine for twenty-four hours, when Dr. Guiteras was called to see him two weeks ago. The penis was enormously enlarged, and of a bluish color. Nothing could be passed through his urethra, or be made to enter it. Multiple incisions were made into the integument and subcutaneous tissue, which was found to be in a gangrenous condition. Upon squeezing the integument, a fluid consisting of pus and urine was

pressed out. A 16 F. sound could then be passed into the bladder. The subcutaneous tissue was then washed out with a bichlorid solution, and the openings were packed with iodoform gauze. The patient has had no further trouble. A stricture was found two-and-one-half inches from the meatus.

The speaker stated that he had never seen a case before where the extravasation was limited to the penis, and had so pressed upon a urethra of the size of the patient's as to cause complete retention.

The patient was very much improved, and the organ was about normal in size.

DR. FULLER thought that perineal section and drainage would have been better to divert the urine from the urethra.

Boettcher's Crystals.—DR. ROBERT W. TAYLOR exhibited a preparation of Boettcher's crystals, and remarked that these crystals are interesting curiosities rather than reliable diagnostic indices. They are obtained by mixing about equal parts of azoospermatus semen and a one-per-cent. watery solution of phosphate of ammonium. In this combination the crystals form quickly in great numbers. When normal semen is used the crystals form quite slowly, and are smaller in size if, indeed, they form at all.

These sperma crystals are quite large, colorless, and transparent. The dominating forms are in the shape of a dagger or of a cuttlefish. In many crystals the dagger's point is broken off, while in some others it does not exist, as each end of the crystal is cut off at an oblique angle. These crystals are so long that frequently they cannot be viewed in one microscopical field. In some crystals a fine longitudinal striation can be made out. When fractured they sometimes have jagged edges. They have a marked tendency to group together, to lie upon, and to cross each other; they sometimes appear to pierce each other, and without break or fissure to form a cross. Again, we find rhomboidal and even square crystals.

Sperma crystals are supposed to be the result of a combination of an organic base with an ammonio-phosphate salt. According to Boettcher, Schreiner, and Poehl, the organic base is derived from the seminal fluid, but Fürbinger claims that this organic base exists only in the prostatic fluid, consequently that when these crystals are found after the addition of the ammonium-phosphate solution to a secretion derived from the sexual tract, the secretion must have come from the prostate. A more recent observer (Lubarsch) is convinced that these crystals have, as their base, the epithelial cells of the testicles. The present observation is directly in support of Lubarsch's statement. The azoospermatus semen, when first examined, contained very many seminal cells, which were thrown off by the lining epithelium of the seminiferous tubules. After the addition of the ammonia-phosphate solution and the lapse of twenty-four hours no seminal cells could be found with the microscope, but Boettcher's crystals were seen in great numbers.

The reliable information given by the microscope makes it unnecessary to fortify the diagnosis by the development and discovery of Boettcher's crystals.

A Case of Psycho-sexual Hermaphroditism.—Reported by Dr. C. W. ALLEN.

Viola Estelle Angell applied to the Home for Friendless Girls in order to have his sex determined. He was born in Nova Scotia in 1874, and at the time of birth some deformity of the genital organs was made out by Drs. Mitchell and Murray, which was supposed to be due to a fright the mother had received during the third month of her pregnancy. He dressed as a girl till he was fourteen years of age, when he changed his attire to that of a boy. A few years later, returning to Halifax, he was followed by a crowd who called out that he was a girl in disguise, and he was arrested. Finding life at home unbearable, he went to Boston, where he worked as a factory girl until he was again arrested for masquerading in woman's clothes. At the age of fourteen he began to have discharges of blood through the rectum and the urethra, which came on at regular monthly intervals and continued for four or five days. Urine has always been passed both through the penile urethra and by way of the rectum.

Examination shows a well-formed penis and testes, with pubic hair of the male type, a rather long perineum, and a rectal opening devoid of sphincter and surrounded by fleshy tabs. A probe could be passed, with the assistance of a rectal speculum, through what appeared to be a fistulous track, near which, high up, was an ulcerated surface. Manual palpation failed to disclose either uterus or ovaries. The testes have always been insensitive to pressure. The pelvic measurements correspond to the masculine type. The right breast is larger than the left, but has little about it that suggests a gland. One hand and one foot approach the feminine type. The conformation of the limbs is that of the male.

The expression of the face is peculiarly that of a woman. The voice is soprano. The psychical characteristics are predominately feminine. The subject is fond of finery, likes to sew, and, indeed, is essentially feminine in all his tastes and actions. He possesses a somewhat exalted mental condition and a perverted judgment, and is rather indolent. His instincts are those of a woman. The penis has never been in the state of erection, according to his statements, and there has never been any discharge similar to an ejaculation of semen.

There has been sexual intercourse with men, but never any desire or attempt with women.

DR. GARRIGUES had seen the case, and, after a careful examination, had decided that it was one of sexual perversion, and had nothing about it that pointed to hermaphroditism.

DR. SCHUELLER, of Columbus, Ohio, had seen the case in the Columbus jail, where an examination had revealed the same conditions as described by Dr. Allen. The parts were then covered with condylomata.

DR. TAYLOR thought the best way of treating the case was to have a picture of him taken and shown to all the police, with instructions to arrest him whenever found masquerading. That would soon cure him.

DR. ALLEN, in closing the discussion, spoke of the duty of physicians toward this class of people, in the interest of society.

DR. EUGENE FULLER then read a paper entitled, "A New Operative Procedure for the Cure of Recto-urethral Fistula."¹

Discussion.—DR. MANLEY had never seen a case such as described by the speaker. He questioned if the patient had been much benefited by the operation.

DR. GALLANT stated that Dr. J. P. Tuttle had reported a new operation which was similar to the one just read, except that it differed in the twisting of the bowel. Dr. Tuttle did not twist the bowel, but in other respects the operation was the same.

DR. FULLER, in closing the discussion, answered Dr. Manley by again telling of the patient's improvement, and explaining why operation was imperative. He claimed priority to Dr. Tuttle only in the manner in which the bowel was twisted, which was a very important feature of the operation.

Selections.

GENITO-URINARY DISEASES.

The Elastic Catheter. PROF. C. POSNER and DR. E. R. W. FRANK (*Centrabl. f. d. Krankh. d. Harn. und Sexual Org.*, 1897, pp. 1 and 77).

P. and F. have made a careful study, both macroscopic and microscopic, of the construction of the woven elastic catheter. This instrument is still indispensable, and the Néleton soft-rubber catheter has not been able to displace it. Still, it has certain drawbacks, the most prominent being its tendency to become brittle with age, and liability to become broken off in the bladder. A glance at the surgical literature of the last decade will show that this is not a rare accident, occurring, to be sure, most frequently with old instruments, or with those which have lain a long time in the shop. The breaking of a comparatively new instrument in the bladder of a patient who had considerable experience in the use of the catheter, and examination of the instrument not revealing to the eye any special cause for this untoward accident, led the authors to make an extended study of the different makes of elastic catheters of English, French, and German origin of the better-known firms and highest grades, and also some of German make of the cheaper grades. Further, the manner in which these different makes were affected by steam, boiling, and antiseptics, when used for the purpose of sterilization, was noted with each make.

By this study the authors have been able to fix a standard to which the instruments of two firms only conformed.

According to their mode of construction, the instruments could be divided into three general types. I. Finely and evenly woven web-

¹ See page 166.

bing, completely covered internally and externally by the lacquer. II. Absence of the inner layer of lacquer. III. Irregularity in weaving of the webbing, so that gaps occur in it, these gaps being filled with the lacquer.

Sections for microscopic examination were best made by freezing process. Examination of the inner layer was made by slitting up the catheter, though this was not so exact as the microscopic examination. By dissolving off the lacquer (for this a fluid composed of two-thirds absolute alcohol, and one-third liq. potas. caustic, sufficed) exact examination of the composition and evenness of the webbing could be made. An important point was the mode of construction of the eye, whether it was woven, or whether it was made by burning or cutting, this was noted both in the microscopic examination and by dissolving off the lacquer. Whether made of silk or cotton could be easily determined after the lacquer had been dissolved. Of further interest to note was the formation of the tip in the conical-tipped catheters and the method of filling up the "dead" end beyond the eye. Colored plates of the microscopic slides accompany the article.

The superiority of catheters conforming to type I. over II. and III. is obvious. They are more easily cleansed, the smooth, inner layer of lacquer does not so easily form lodging places for pus, urine, and germs, and the webbing is protected from fraying. The woven eye presents a stronger instrument, rendering danger of fracture at this point less liable to occur, than is the case where the eye is cut out, or burned out. Of the specimens examined only those of two firms conformed to this type, one German firm and one English (only one English make was examined). The English instrument differed slightly in that the lacquer was rather more brittle, and the "dead" end beyond the eye was not filled.

Instruments from three of the best-known French makers conformed to types II. and III., the inner layer of lacquer being very slight, or wanting entirely, and in some the weaving was loose, leaving gaps filled by lacquer. Further, while the webbing of the English and German instruments was of pure silk, those of French make was of cotton, or mixed material, and the eye of these latter was formed either by cutting or burning.

Instruments of the cheaper German make were found to be ill-made and dangerous, conforming mostly to type III.

The action of sterilizing agents, as steam, boiling, carbolic, and bichlorid solutions were shown to have a gradually deteriorating effect upon all, though, naturally, the better grades withstood the action better than the cheaper ones. These instruments, however, can now be used much longer without deterioration, when subjected to the method of sterilization advocated by Janet (*Annales d. Mal. d. Org. Genito-Urin.*, pp. 26 and 122) and E. R. W. Frank (*Berl. Klin. Wochenschrift*, 1895, No. 44), namely, the use of the vapor of formalin, or trioxymethelen. The authors express the hope that the demand by physicians for better-grade instruments of this character will force the poorer, dangerous grades out of the market.

Foreign Body in Male Bladder, Suprapubic Cystotomy. DR. J. O'CONOR (*N. Y. Med. Jour.*, 1897, p. 457).

Patient was admitted to the British Hospital (Buenos Ayres) having a bit of broken catheter in the bladder. Four weeks before, a friend of the patient, seeing him urinate, thought that his power of expulsion was feeble, and told him that he had a stricture, that he, himself, had once had stricture, and had cured himself with an instrument which he would lend him. The patient, accordingly, availed himself of this advice, and carried home an old, gum-elastic catheter, No. 6 E., which he inserted with ease into the bladder. A few hours later he attempted to urinate, the stream suddenly stopped, followed by severe pain; after straining, he passed a broken bit of catheter, which was followed by profuse hematuria. That night he had chill, followed by fever, and sent for a physician, who, examining the catheter, found that fully a third was missing. The patient suffered from cystitis and hematuria until admission to the hospital. Examination under chloroform revealed a foreign body in the bladder. An attempt was made to remove it with a lithotrite; this failing, suprapubic cystotomy was performed, and four pieces of the catheter, coated with phosphates, and measuring in all three inches, were removed. Immediate suture of bladder-wound was made, and a gauze drain left in lower angle of abdominal wound, which was also sutured, and a small catheter left *à demeure*. Patient made an uninterrupted recovery.

REPORT OF FRENCH ASSOCIATION OF GENITO-URINARY SURGEONS.
(*Conclusion.*)

Pathogenesis, and Treatment of Hydronephrosis. LEGUEU. (*Ann. d. Mal. d. Org. Gén.-Urin.*, 1896, p. 982.)

Clinically, hydronephrosis may be produced quickly, and thus give rise to pain; or slowly, in which case the presence of a tumor is the first phenomenon to engage our attention. Experimentally, hydronephrosis may be produced by closure of the ureter by foreign body, ligature, or by kinking, or twisting. Where the closure is incomplete hydronephrosis arises slowly, but is distinctively larger than in complete closure.

The causes of hydronephrosis may lie, (1) external to the urethral wall, producing pressure—frequent, but seldom recognized; (2) within the lumen, from calculi; (3) in the urethral wall, by kinks, or twists, such as arise in movable kidney, and may be intermittent, or fixed. Group 3 is the most frequent cause. el
el

Nephroraphy, in movable kidney, prevents hydronephrosis, or causes the disappearance of a slight grade.

If the kidney is destroyed, nephrectomy is indicated, in which case L. prefers the transperitoneal route. If the trouble is of moderate degree, the lumbar route is preferable, as it may be possible then to preserve the kidney.

Nephrectomy for hydronephrosis is relatively of slight gravity, as the opposite kidney has become habituated, and is probably acting compensatorily.

ALBARRAN.—Hydronephrosis from calculus is not so rare as Legueu intimates, since Albarran knows of ten cases in addition to the two reported by Legueu. Albarran operated upon two cases.

In hydronephrosis, even when the sac is very large, nephrectomy is not always necessary. By a preliminary nephrotomy we may determine whether the kidney still secretes urine, and thus, perhaps, be able to save it. A. cited a case.

Pathological Physiology of the Increase in Volume of the Kidney and of the Polyuria in the Crises of Intermittent Hydronephrosis. ALBARRAN.—Increase in volume. Congestion of the kidney plays a more important *rôle*, especially in the beginning of this disease, than is generally admitted, not to recognize this may cause us to be deceived as to the hydronephrosis. After complete ligation of the ureter the kidney may become remarkably enlarged in the first few hours, while the renal pelvis may contain but little fluid.

This congestion of the kidney in crises of movable kidney, with or without a hydronephrosis, may cause a hematuria. A. has observed three such cases.

In advanced cases, where a sac has formed, damming back of retained urine plays a greater *rôle*, but congestion also takes part in the enlargement of the kidney.

Polyuria, the polyuria after a crisis in intermittent hydronephrosis, is more dependent upon increased secretion than upon the outflow of pent up urine.

DR. MONTFROFIT operated successfully upon three cases of hydronephrosis, in which the kidney tissue was reduced to a mere shell, and asked whether, with such conditions, we could hope that such a kidney could functionate.

Two Cases of Anuria Treated by Nephrotomy. CHEVALIER.—C. gave history and described operation of two such cases. One was dependent upon tuberculosis of the urinary organs, the other, upon existing lithiasis. In each case an incision of moderate extent was made into the kidney, and a drain inserted into the pelvis. In the first case, drainage was all that was sought; in the second case, anuria had existed fourteen days, the case was almost *in extremis*, so that this was all that could, with safety, be done. In the first case relief was given, the patient lived sixteen days, and died of the pulmonary tuberculosis; the second case was cured.

DURET, in a case of anuria of sixteen-days' standing, had to content himself with a blind incision into the kidney tissue, and the insertion of a drain. After passing some sand the case got well.

LEGUEU.—Even with marked changes in the kidneys we cannot conclude that they are unable to perform their functions.

POUSSON was glad to see that nephrotomy, as advocated by Demons and himself for anuria from calculi, was constantly getting new adherents.

olypoid Vegetations of Urethra and Bladder in a Woman. REBOUL.—The patient, thirty-five years old, presented polypi about the

meatus and along the urethra. These were removed by the curette and galvano-cautery, after slitting the urethra along its posterior wall and resuturing. They soon recurred, and involved the bladder, gave rise to hemorrhage and retention. Reboul performed supra-pubic cystotomy, removed the growths in the bladder, and inserted a Guyon-Périer drain, which was replaced in two weeks by simple catheter; after three weeks, a catheter was placed *à demeure*. The urethral growths disappeared, except one small nodule, which was removed by curette. Thus far, no return.

Two Cases of Suppurative Gonorrheal Arthritis. MALHERBE.

1. A young woman, five months after delivery, had rheumatism in different joints, finally settled in one knee, and suppuration ensued. M. drew off 100 g. of pus by means of a trocar, through which he washed out the cavity with Van Swieten's fluid. Case recovered within a month with fibrous ankylosis. The pus removed was sterile.

2. A man, forty-three years, a gouty subject, had had frequent attacks of gonorrhea. September, 1896, he began to have pain in the left knee, followed by marked flexion and swelling. Immobilization being unsuccessful, the joint was aspirated, half a glass of pus being withdrawn; the joint was washed out with 1-4000 solution of bichlorid. Patient's condition improved. The pus removed in this case was found, after repeated attempts to cultivate it, to contain very few of the staphylococcus albus.

Local Anesthesia, with Eucaine. LEGUEU.—L. finds eucaine less poisonous than cocaine, and capable of sterilization. Six cg. of hydrochlorate of cocaine killed a rabbit immediately, while another rabbit lived 1½ hours after injection of 8 cg. of eucaine.

The anesthetic property of eucaine seems to equal cocaine.

For operations on urethra, dilatation, urethotomy, etc., L. uses one-per-cent. solution, and injects three to five centigrams. For cystoscopic examination, sixty to eighty grams of a solution, 1-1000, are employed.

Large and Old Pyonephrosis, with Fibrocartilaginous Walls, Containing a Pus-like Fluid, Probably Congenital Origin. DURET.—The patient, a man forty-seven years old, had influenza five years ago. Since then he has been weak. Examination of the abdomen by his physician, on account of colic, revealed existence of a large tumor on the left side.

Urine normal, contained no albumen, sugar, or pus, still the tumor was believed to be of the kidney.

Operation: Vertical incision from hypochondrium to the iliac crest. Numerous protuberances rendered the separation slow. The tumor was rendered smaller by incision of some of the cysts, letting out, thereby, a large amount of thick, creamy, pus-like material. After removal of the tumor, the cavity was packed with iodoform gauze.

Patient did well for four weeks, and was then carried off by a pleuropneumonia.

Examination of the tumor revealed no kidney tissue. The tumor was composed of numerous cysts, separated by thick, fibro-cartilaginous walls, containing a thick, purulent material, resembling the contents of dermoid cysts. The ureter was very thick, and of cartilaginous hardness. The tumor appears to have been of congenital origin.

Surgical Interference in the Course of Purulent Urethrites. VIGNERON.—Strictures, congenital narrowing of the meatus, or any portion of the urethra, diverticula in the form of abscesses or fistula of infectious or traumatic origin, constitute the most frequent causes for the intractability of a chronic, gonorrheal urethritis. Early removal of such conditions are indicated to insure successful treatment of discharge, and, thanks to the method of Janet, the necessary measures may be undertaken under antiseptic rules, even if gonococci are present. The histories of fourteen cases are presented by Vigneron.

JANET admitted the justifiability of surgical interference upon the prepuce and glans during an acute gonorrhea, but warned against urethrotomies and dilations until after the removal of the gonococci by irrigations, unless the strictures are so narrow that irrigation cannot be done.

Gonorrhea and Prostatism. ERAUD.—E. calls attention to a form of disease of the prostate, sometimes met in elderly men. The symptoms are those which accompany prostatic hypertrophy. If the patient passes the urine in two portions filaments are found present, and sometimes, though this is seldom the case, they are found to contain gonococci. Besides this, the prostate does not present the characteristics of genuine hypertrophy, but only simple swelling. In treatment the difference between this form of prostatitis and prostatic hypertrophy is easily noted, as the former easily yields to simple antiphlogistic measures, while in prostatic hypertrophy the condition of the patient remains unchanged, or gets worse. Perhaps failure of treatment, in some cases of enlarged prostate, may depend not infrequently on such gonorrheal infections, either ancient, or recent.

Metastatic Cancerous Adenitis in Supraclavicular Region in Cancer of the Prostate. CARLIER.—In the year 1886 Troisier called attention to enlargement of the supraclavicular lymphatic glands of the left side as indicative of a propagation from cancer of the abdominal as well as the thoracic viscera. C. has observed this symptom in a man thirty-one years old, suffering from carcinoma of the prostate. The patient presented himself two years before the beginning of symptoms pointing to trouble with the urinary organs, having a glandular enlargement the size of a pigeon's egg, which lay above the middle portion of the left clavicle. Patient died in 1893 of uremia, no other organ being attacked by carcinoma. The tumor (prostatic) was a soft, medullary carcinoma, as shown by examination of particles spontaneously voided in the urine. Thus involvement of the supraclavicular glands, especially of the left side, may,

in a doubtful case of prostatic enlargement, point to the direct diagnosis.

Artificial Testicle after Castration. CARLIER.—C., in a case of old hematocele of the right testis, was obliged to remove the testis, as it could not be separated from the hematocele. The testis he replaced by an artificial silver one, which he happened to have, having performed total resection of the tunica vaginalis. C. believes that it is well in such cases to extirpate the tunica vaginalis. He thinks that an artificial testicle of silver is preferable to those of silk, rubber, or celluloid. In this case it was interesting to note that there was almost complete atrophy of the right side of the prostate.

LOUMEAU, in two cases of castration for prostatic hypertrophy, had made use of artificial testes made of wound silk. The tunica vaginalis, he found, was tolerant of foreign bodies, while in one of his cases, in which one artificial testes was negligently placed in the scrotal tissues, outside of the tunica, it was not well borne, and came away. The artificial testicle of silk in the beginning is hardly to be distinguished from the natural one, later, however, they absorb salt and organic matter, and become hard, so that they are more like those of metal, or glass. At another opportunity L. proposes to try them made of soft rubber.

The Value of Resection of the Vas Deferens in Prostatic Hypertrophy. CARLIER.—C. has performed resection of the vasa deferentia in seven cases. Two are not presented for consideration, one being too recent, and in the other, the operation was undertaken for dysuria, in consequence of stricture of the perineal urethra.

In the other five cases, there was no improvement which C. could ascribe to the operation. The fact that the urine became clearer he ascribed rather to the treatment following the operation. He also believes that the favorable results in the hands of others are due, not so much to the resection as to the methodical after-treatment.

C., in performing the operation, makes a small, cutaneous incision on one side only, draws out the vas, and makes resection of desired length; then, with a steel sound, he breaks through the fibrous septum, and draws out the vas of the opposite side, and resects that. The small, cutaneous wound is covered with collodion.

Operations for Prostatic Hypertrophy. BOUSQUET.

1. A patient, sixty-six years old, had his first retention of urine after removal of the catheter, which had been placed *à demeure* for one week. Catheterization became difficult. Double castration. There was no improvement, though there was marked atrophy of both lateral lobes of the prostate. Catheterization still difficult. This was found to be due to a prostatic bar in the region of the bladder neck. Catheter could be passed, with the assistance of the finger inserted in the rectum.

2. A patient, seventy-seven years old, twice in the previous six months had complete retention; each time, however, there was spontaneous recovery. After the third retention catheterization was re-

sorted to, and then for eight months there was no spontaneous flow of urine.

The prostate was the size of a child's head; catheterization painful and difficult. Resection of the vasa deferentia was performed. Two days after the operation catheterization became easy, and on the third day urine flowed spontaneously for the first time. In a week the patient urinated completely alone. The prostate was reduced two-thirds.

Carlier thought, in case 2, the result was to be ascribed to the after-treatment, as the patient had never had previous careful and methodical catheterization.

BOUSQUET maintained that catheterization had never reduced the size of the prostate; in this case it was diminished two-thirds.

LOUMEAU had performed resection of the vas in four different cases without result. In two cases there was cessation of frequent recurrence of epididymitis, but that was the only result he could ascribe to the operation.

CHEVALIER.—Under the influence of regular catheterization, the enlarged prostate may be reduced one-half if this is carried out in the early stages; in the older cases also the diminution may be marked.

GUIARD is convinced that often a successful result is ascribed to castration which has really been attained by regular catheterization and corresponding antiseptis. G. gave the history of a case in which, after long, careful, methodical treatment for three months, an excellent result was obtained, which, had castration been performed, would have been ascribed to that operation.

VIGNERON had only once performed castration for prostatic hypertrophy. The result, however, was satisfactory. The patient, having had frequent and painful urination, suffered from retention, for which a catheter was placed *à demeure* for eight days. The history extended over a period of two years, the frequency and pain increasing in severity, the urine remained always clear, though it increased in quantity, and was never voided spontaneously, but through a catheter. After castration, the patient urinated easily, and without pain.

Double Castration in a Prostatic in whom Suprapubic Cystotomy and Resection of the Vas Had already Been Performed. CHEVALIER.—The patient, fifty-nine years old, had had symptoms of prostatism for ten years. His first attack of acute retention occurred three years before; cured by catheterization, having lasted eight days. The second attack, two years ago, lasted three days. Third attack, a year ago, October, 1895, patient having made false route, aspiration was performed. Suprapubic cystotomy was then performed, and from that time on the urine evacuated entirely by the fistula; two months later resection of both vasa deferentia, without improvement; four months later the fistula was closed by operation and castration at the same sitting. This was a success, the fistula remained closed, urination was spontaneous every two or three hours, and the prostatic enlargement was reduced one-third. Examination of the resected cords showed complete impermeability.

Success with castration is only to be expected when the prostate is half soft, showing preponderance of the element of congestion. Early operation promises the best success.

LOUMEAU, in two cases of castration, saw very good results. One patient had had complete retention for a year, which completely disappeared within thirty-six hours after the operation. In the second case there was improvement, but five months after the operation there remained thirty c. cm. residual urine.

CARLIER has observed a case of long-continued mental disturbance following castration.

CLADO performed castration in a case without result.

CHEVALIER.—We must not forget that in these cases the bladder and arteriosclerosis play the same *rôle*. There are cases in which the influence of the prostate upon the retention amounts to nothing.

Disinsertion of the Recti Muscles in Cystotomy. DESNOS.—In order to gain room and light in certain operations on the bladder, without the disadvantage due to transverse incision of the recti muscles, D. advises prolonging the incision in the linea alba to within one cm. of the root of the penis, cutting down upon the symphysis, and raising the periosteum with the insertion of the recti muscles on each side. After operation the periosteal flaps may be sutured with silk, or catgut; union is prompt and the tendency to ventral hernia is avoided.

CLADO did not believe this operation necessary; incision of the recti muscles sufficed.

DESNOS reiterated that the transverse incision of the recti rendered some risk of imperfect union, even no union at all, and led to weakness of the abdominal wall.

Operation for Vesico-vaginal Fistula by Suture in Three Stages. ASSAKI.—In a case of vesico vaginal fistula in the anterior vaginal vault, through which all the urine passed from the bladder. A. operated in the following manner:

An elliptical incision was made in the vaginal mucous membrane surrounding the fistulous opening, but so arranged that the opening was nearer one pole of the ellipse. The vaginal mucous membrane within the incision was dissected up to the cicatrix, which was then excised. The mucous membrane of bladder about the bladder-end of the fistula was scarified, drawn through the opening and sutured by two transverse sutures. The connective tissue was sutured over this by sutures placed in a vertical direction, and over this again the edges of the elliptical incision were sutured by transverse sutures. Thus each line of suture had a different direction. The vagina was tamponed with gauze, and a catheter passed into the bladder, the external extremity being placed in a sterilized urinal, filled with Van Swieten's fluid. Cure by the twentieth day.

CLADO thought this method excellent in the ordinary cases. There are two classes of cases: (1) Those in which the fistulæ are small, non-callous, without peripheral adhesion of the vaginal wall, and situated near the cervix uteri; these should be operated upon

through the vagina. (2) Vesico-cervical fistulæ, those near the cervix which have much callous, fistulæ with extensive cicatrices, or adherent to the pelvic bone, with large destruction of the vaginal wall. In a study of this condition, in conjunction with Professor Duplay, they had come to believe that the best method of attack was from the bladder outward after performing cystotomy.

Therapeutic Notes.

Thyroid Preparations in Skin Disease.—ZARUBIN (*Archiv. f. Derm. und Syph.*, Bd. xxxvii, ht. 3) thinks its use only permissible when the patient is kept under observation constantly, owing to its well-known dangerous characters. It was useless in three cases of psoriasis and one of sycosis. Two of the former grew worse during its administration.

Formalin in Ringworm.—The *Therapeutist* says that the use of this drug was suggested in Guy's Hospital by the discovery that trichophyton cultures were killed in one night by leaving the stopper out of a formalin bottle. Dr. Alfred Salter, the inventor, treats his cases in this way. Fluid formalin is brushed into the patches for ten minutes, and the application repeated every other day for four treatments. Of forty cases, only four required repainting from failure to eradicate. Three cases suppurated, but the follicles were not destroyed. A thick crust is produced and an emollient is indicated to facilitate its removal.

Burns.—TSCHMARKE (*Deutsche Zeitsch. f. Chir.*, vol. xlv, p. 346) shows, in an exhaustive article, that it is of the greatest importance to render the part aseptic, for the patient may die of blood-poisoning after recovery from shock. His method directs thorough disinfection of the wound, powdering it with subnitrate of bismuth and covering with iodoform gauze. After a few days the bismuth must be replaced by boric-acid ointment, as it irritates the raw surface. Every dressing is allowed to soak off in the bath before being renewed.

Eneuresis in Women.—NASON (*Brit. Med. Journal*, February 8, 1896) treats nocturnal incontinence in women by distending the bladder at low pressure with boric-acid solution and passing a constant current through it, placing the negative pole in the fluid and the positive over the lumbar spine. He cured a case after twenty-years' standing, and increased the capacity from four to twenty ounces.

Lupus.—DIX (*Med. and Surg. Reporter*, February 27, 1897) treated an indolent ulcer of three-years' standing with antinosine until it was transformed into a healthy, granulating surface. The iodine compound was then mixed with twenty parts of bismuth, which combination was continued until healing was complete.

Items.

PRELIMINARY PROGRAM—AMERICAN ASSOCIATION OF GENITO-URINARY SURGEONS.

The eleventh meeting of this Association will take place at the Shoreham Hotel, Washington, D. C., on May 4, 5, and 6, 1897, in conjunction with the Congress of American Physicians and Surgeons.

The following papers have been promised:

"Priapism." By Dr. R. W. Taylor of New York.

"Results after Nephrectomy for Renal Tuberculosis." By Dr. L. Bolton Bangs of New York.

(a) "Report of a Fatal Case of Prostatic Abscess."

(b) "Report of the Surgical Anatomy of the Kidney." By Dr. George E. Brewer of New York.

"Report of a Case." By Dr. William Judkins of Cincinnati.

"A New Method of Removing Vesical Polypi, with Cases." By Dr. George Chismore of San Francisco.

(a) "Chronic Contractions of the Prostatic Fibers Encircling the Vesical Neck."

(b) "Tubercular Necrosis of the Prostate." By Dr. Eugene Fuller of New York.

"A Case of Cystine Calculus in the Male Bladder." By Dr. Paul Thorndike of Boston.

"Urinary Inflammations and Disorders in Connection with Oxaluria and Lithemia." By Dr. Bransford Lewis of St. Louis.

"Detection of Kidney Stone." By Dr. Edward Martin of Philadelphia.

"Nephrectomy for Cystic Adenoma in a Pregnant Woman." By Dr. Charles L. Scudder of Boston.

(a) "An Aid to the Discovery of the Tubercle Bacillus in the Urine."

(b) "Clinical Observations on Loose and Displaced Kidney." By Dr. John P. Bryson of St. Louis.

"Report of a Case of Hernia Testis." By Dr. G. W. Allen of Boston.

(a) "Photography of the Interior of the Living Urinary Bladder."

(b) "Another Urethroscope." By Dr. W. K. Otis of New York.

W. K. OTIS, M.D., Secretary,

5 West Fiftieth street, New York.

THE UNNA DERMATOLOGICAL PRIZE.

The subject for investigation this year is whether and to what extent the previously employed specific stains for Elastin are applicable in the case of Elacin. Competition is open to all. The prize of 300 marks (\$75.00) will be awarded by Professors Krause and Hoyer. The work must reach Leopold Voss, Hohe Bleichen 34, Hamburg, by December 1, 1897.

The College of Physicians and Surgeons, Chicago, has recently become the Medical School of the University of Illinois.

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Original Communications.

ENDOTHELIOMA OF THE CORPORA CAVERNOSA.— REPORT OF A CASE.

By SAMUEL ALEXANDER, A.M., M.D.,
Professor of Genito-Urinary Surgery and Syphilis in the Bellevue Hospital Medical College; Surgeon to Bellevue Hospital;

AND

EDWARD K. DUNHAM, M.D.,
Professor of General Pathology, Bacteriology, and Hygiene in the Bellevue Hospital Medical College; Director of the Carnegie Laboratory.

I. CLINICAL HISTORY.

McQ., aged about fifty years, was referred to me by Dr. Clarence Sharp of this city. He stated that six months before he had noticed that his penis curved upward during erection, and upon examination he found a small lump in the penis at the point of greatest curvature. Since then this had gradually increased in size and sexual intercourse was impossible. I found on the dorsum of the penis, about one inch from the symphysis pubis, an indurated mass situated in the substance of the corpora cavernosa. It measured about $2\frac{1}{2}$ centimeters long by $2\frac{3}{4}$ centimeters broad. It was elastic and was firmly attached to the fibrous sheath of the penis. It extended from the middle line equally into each corpus cavernosum. The skin covering it was of normal appearance, and was freely movable. It was wholly painless.

It was confined to the corpora cavernosa and did not involve the corpus spongiosum. There was no obstruction to urination. The inguinal nodes were not involved. The patient was thin and pale, and had symptoms of chronic gastric catarrh.

There was no family history of cancer, and no history or evidence of syphilis.

Examination of the urine negative as to albumin or sugar.

The clinical signs and history of the case led me to believe that the growth was an example of well-marked "fibrous induration," or "fibrous sclerosis" of the corpora cavernosa.

As I was desirous of obtaining a specimen of this latter condition for pathological study, I asked permission to remove the growth but at the same time I assured the patient that the operation would not relieve the deformity of the penis during erection. The operation was performed at Bellevue Hospital on June 6, 1894. A linear incision was made over the growth and the skin was reflected on each side. The fibrous sheath of the penis was much thickened, but the tumor was not encapsulated. It involved both of the corpora cavernosa for about one-third of their thickness, and I was obliged to cut it out of the spongy tissue. Hemorrhage was controlled by pressure and the skin incision was closed without drainage. The wound healed by primary union. The growth was sent to the Carnegie Laboratory for examination, and Professor E. K. Dunham's report forms a part of this paper.

During the following six months the patient reported from time to time at the hospital, and when last seen by me there had been no return of the disease.

Dr. Sharp informs me that he saw the patient in September or October, 1896, and that there had been no recurrence of the growth. The deformity of the penis during erection was greater than before the operation. Since last seen by Dr. Sharp the patient has died, but I have as yet been unable to ascertain either the cause of death or the nature of his disease.

The special interest of this case lies in the great rarity of endothelioma of the penis, and in the clinical resemblance of the tumors in this case to those benign growths classified under the general name of fibrous induration of the corpora cavernosa.

Our knowledge of the pathological anatomy of these latter growths is so limited and imperfect, that in view of the clinical history of this case we must await further evidence before we can say that all of the indurations of the corpora cavernosa now included in the name "fibrous indurations" of the corpora cavernosa are non-malignant.

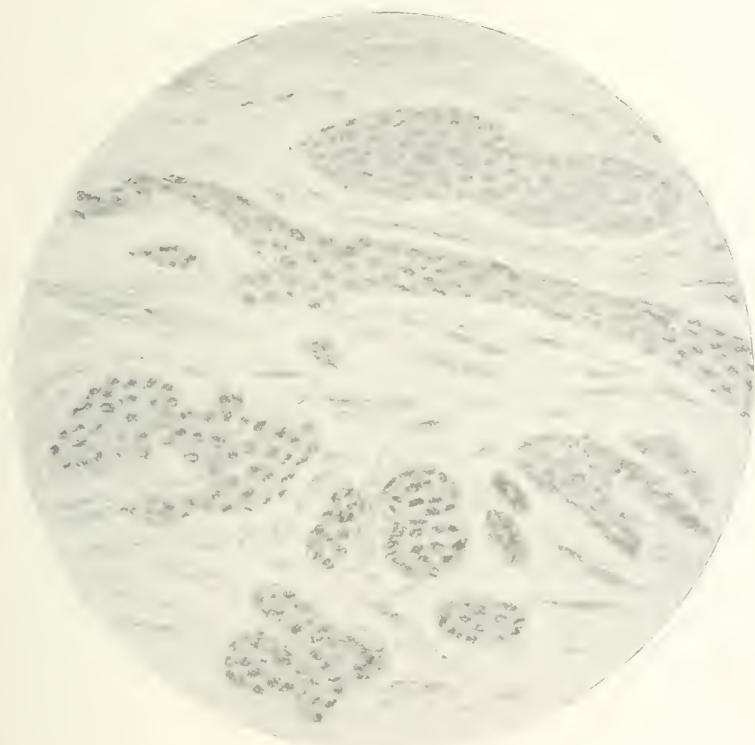
It is also of interest to note that although the tumor seemed to be growing, and microscopically showed marked signs of malignancy, no return had occurred for more than two years after its removal.

II. MICROSCOPICAL STRUCTURE.

Upon microscopical examination, the tumor presented a general alveolar structure, the alveoli having a plexiform arrangement and evidently communicating with each other.

The tissue between the alveoli consisted of fibrous bands containing a variable amount of non-striated muscle. In a few places the muscular fibers constituted the major part of the tissue, but in general

FIG. 1.



The writer is indebted to his friend, Dr. Geyser, for the illustration accompanying this report.

there were only a few muscular fibers. This became continuous, at the surface of the growth, with a dense, perhaps incomplete, fibrous capsule, containing arteries of moderate size. The interalveolar fibrous tissue was vascularized by small arteries. Toward the periphery of the growth it was the seat of a marked round-celled infiltration, and, in some places in the body of the growth a similar infiltration of moderate degree was observed.

The presence of smooth muscular tissue in the interalveolar fibrous bands leads to the conclusion that they were the trabeculæ, and that the spaces they enclosed were the sinuses of the corpus cavernosum. There were places, however, in which it appeared as though the alveoli were situated within the tissues of the trabeculæ. These alveoli were much smaller than those which appeared to correspond to the sinuses of the corpus, and they were surrounded by a fibrous tissue which was apparently of new formation.

The alveoli varied greatly in size and form. They were filled with cells containing large, oval, vesicular nuclei, each of which contained a single very large nucleolus. The chief interest of the specimen hinges upon the nature and origin of these cells. They varied considerably in shape and in size. Many of those lying close to the walls of the alveoli appeared cubical in form and possessed a comparatively small amount of a granular protoplasm, surrounding the nucleus about equally on all sides. Others were oval, polyhedral, or flattened. The larger cells possessed protoplasmic bodies which were only slightly granular and nuclei of strikingly large size. Near the middle of some of the larger alveoli the cells had undergone degenerative changes; the nuclei no longer took up the coloring matters used to stain the sections, and the granular protoplasm was replaced by irregular masses of a highly refracting, apparently homogeneous substance. In the centers of other alveoli these degenerative changes had not taken place, but, in some cases the cells were flattened and imbricated so as to form groups somewhat resembling the "pearl bodies" occurring in epitheliomata springing from stratified epithelium. In some places the cells appeared to be in direct contact with the fibrous tissue composing the walls of the alveoli, but in other places the latter were covered by a layer of normal endothelium having no connection with the cells filling the alveoli.

The nuclei of some of the cells in the alveoli presented the mitotic figures characteristic of the karyokinetic changes inaugurating cell division. There can, therefore, be no doubt that the tumor was actively growing at the time of its removal. At some points at the periphery of the tumor the fibrous tissue forming its capsule contained a few rows of cells which were continuous with those in the neighboring alveoli. These rows of cells appeared to occupy interstices devoid of distinct lining and their presence in those situations was regarded as an evidence that the neoplasm was infiltrating the tissues surrounding it. At these points those tissues were the seat of a marked round-celled infiltration; a circumstance tending to con-

firm the idea that the growth was invading its surroundings, and had a tendency to spread and perhaps undergo metastasis.

In some places leucocytes were seen among the cells occupying the alveoli, but no red blood-corpuscles were observed within the alveoli.

The structure of the growth, its history and location, lead to the conclusion that the tumor is an endothelioma or endothelial cancer, and that there was a chance of its spreading to other parts of the body had it not been removed.

The cells within the alveoli probably derived their origin from the endothelium lining the sinuses of the corpus cavernosum, and, as they multiplied, invaded the neighboring sinuses and the tissues surrounding them. The homogeneous masses described as lying near the center of some of the alveoli were probably the remains of endothelial cells which had undergone hyaline degeneration; a change not uncommon in the endothelia of neoplasms.

These endotheliomata of the penis are certainly of very rare occurrence. The writer has met with but a single published report of a case resembling that under consideration. It was described by M. Maurer in a dissertation published in Halle in 1883, and entitled, "Ueber einem eigenthuemlichen Fall von Angiosarkom (Endothelioma intravasculare)." The writer has been unable to obtain a copy of this dissertation and does not know whether plates giving the details of its minute structure accompany the description of the growth. But a pretty full abstract of that description is contained in Ackermann's article on "Die Histogenese und Histologie der Sarkoma," in Volkmann's *Sammlung Klinische Vortraege*, No. 233-234, on page 40. That growth consisted of endothelial cells which sprang from those lining the sinuses of the corpus cavernosum and invaded and filled those sinuses. The growth gave rise to metastatic tumors of similar nature in the groins and in the skin of remote parts of the body. One such secondary tumor was situated on the dorsum of one of the feet. No statement is made as to the duration of the primary growth, but the patient was admitted to the hospital when the secondary growths in the groin had already become ulcerated, and died about four weeks later.

These facts concerning the case reported by Maurer sufficiently emphasize the conclusion that the tumor now under discussion is of malignant nature.

A CASE OF HEREDITARY AND CONTINUOUS SHEDDING OF THE FINGER-NAILS.

By DOUGLASS W. MONTGOMERY, M.D.,

Professor of Diseases of the Skin, Med. Dept. of the University of California.

ON October 3, 1895, Dr. F. Dudley Tait sent me, as an interesting case, a gardener, who had been troubled since his birth with a constant shedding of the finger-nails. The patient, a native of Les Basses Pyrénées in France, was a tall, large-boned man, with no superfluous flesh, and in excellent health. He was thirty-five years of age.

Hereditary Antecedents.—He said that his mother's nails fell like his own, one or two nails being affected every seven or eight months. His mother had two brothers whose nails fell every three years or so. She had also two sisters, one now living at Bordeaux, and the other in Paris, but he does not know whether they have the affection of the nails or not. He did not know anything about his maternal grandparents in this respect. His father's nails were bad, but did not shed. One paternal aunt and two paternal uncles, and one cousin, the daughter of one of these uncles, also had bad nails, rough and chalky, but they did not fall off. In his own family there is only one other child, a brother, and his nails are normal. The patient himself is unmarried, and has no children.

Morbid Antecedents.—He had a severe attack of smallpox when thirteen years of age, which left his face plentifully pitted with smallpox scars.

Shortly before coming to me in October, 1895, he acquired a chancre, followed by indolent enlargement of the lymphatic glands of the groins, and patchy alopecia of the hair of the head. In fact, Dr. Tait was treating him for syphilis when he sent the patient to me on account of the peculiar affection of the nails. The syphilis had no effect whatever on the shedding of the nails, which went on afterward just as it had been doing before. The patient had no stigmata whatever of hereditary syphilis.

In relating his case, the man told me that some one or two of his nails were always falling, one or more being involved every seven or eight months. An affected nail grows dull, yellowish-white in color directly over the lunula, or to one side of it, and then begins to lift away from the nail-bed from behind forward, till it falls off. It is a slow process, at times taking three months for the shedding to be

complete. After the nails have fallen off the patient told me the new ones grew in, in from three to eight months, and were perfectly normal. There is no pain nor the least subjective inconvenience connected with the process, and the new nails are in every respect normal, being strong, firm, smooth, translucent, pink, glossy, and well-shaped. The patient said he had noticed that when the thumb-nail of one hand was falling off, the little finger-nail of the same hand was also shedding, and that the index and ring finger-nails were also inclined to be affected together in the same way. The middle finger, he said, did not seem to pair off with any of the rest. Apparently, in substantiation of this, at the date of writing this paper, on April 24, 1897, the thumb and little finger of the right hand were affected, while the index and ring finger-nails of the left hand were falling off. Just at present, however, I cannot say this pairing really occurs, for the most recently affected nail is that of the right little finger, the one before that was the left index, just before that the right thumb-nail, and immediately previous to that the left ring finger-nail had fallen, so seemingly the affection alternated from one hand to the other. To establish any order, however, either in series or in time, further observations would be necessary.

On April 1, 1897, I had an opportunity of seeing the exfoliative process at its commencement. The nail of the right little finger was just beginning to become dull white at the radial side of its base, at the same time the nail of the left index finger was a little further advanced, and was beginning to lift at the ulnar side of its base, and the right thumb-nail was still further advanced, and was well loosened from its bed, both directly over the site of the lunula, and toward the ulnar side of the base. He said that he thought he first noticed the involvement of this thumb-nail about fifteen days previously, and the nails of the right little finger and left index had become affected subsequent to the thumb-nail. The left ring finger-nail had been shed for some time, and the nail-bed was occupied by a roughened, horny mass. The man had large powerful hands of equal size, and caloused palms. The backs of his hands, when seen in March, were red and roughened by his occupation and from exposure to the dry, harsh winds of Spring. The fingers were long and bony, and the right little finger had a bulbous tip, which, however, seemed to be simply an accidental deviation from the normal shape. The general hairy covering, as well as that of the scalp, was dark, vigorous, and in all respects normal, excepting a commencing alopecia senilis at the vertex. He had excellent teeth. A search for

indications of any of the diseases with which disease or shedding of the nails is sometimes associated was fruitless.

There were no indications of psoriasis. The patient had some keratosis pilaris on the extensor surfaces of the upper arms, a little dandruff of the scalp, which he had noticed for the past two or three years, and one slight indentation on the surface of the left middle finger-nail. All these symptoms, which sometimes accompany psoriasis, are, however, so frequent in human beings as to be almost considered normal, and certainly are not sufficient to raise even a suspicion of psoriasis. The roughness and redness on the backs of the hands were transitory, and due to his occupation and the season. This erythema did not extend down on the fingers, nor did it look like a true eczema. Furthermore, neither psoriasis nor eczema give rise to shedding of the nails, but to more or less marked deformity, and there was no deformity here. There were none of the generalized, exfoliative diseases of the skin present, such as pityriasis rubra, or dermatitis exfoliativa, or scarlatinaform erythema. The man's gait was correct and firm, the patellar tendon reflexes normal, eyesight remarkably good, and the pupil reflexes, both for light and distance, were present. The sensation for touch, pain, heat, cold, weight, and the sense of locality were normal, and there were no pains, fulgurating or otherwise, so there was no reason whatever to suspect locomotor ataxia as a cause for the shedding of the nails. Furthermore, according to Bonieux, the exfoliation of the nails in locomotor ataxia usually attacks the great toe-nail, and is preceded by a sense of discomfort, and frequently by subungual hemorrhage, none of which were present in the case in hand. There was no excessive sweating, nor congestion of the hands, nor abnormal feeling of heat or cold, nor were there any symptoms of Basedow's disease present, so that the exfoliation was not due to any evident circulatory disturbances.¹ There was no sugar in the urine, or other symptoms of diabetes, and it may be mentioned here that the evidence that defluvium of the nails is ever dependent on diabetes is very slight. Bonieux has only been able to find one case mentioned in the literature.²

On April 24, 1897, the patient brought me the urine passed in the previous twenty-four hours. There were eighty-six ounces of a pale, straw-colored, slightly acid urine, having a specific gravity of 1016. No sugar was found in it, either with Fehling's test or by the

¹"De la Chute des Ongles dans l'Ataxie Locomotrice," par Henri Bonieux, *Thèse de Paris*, 1883.

²"De la Chute des Ongles," par Henri Bonieux (vide supra).

polariscope. There was a slight cloud of albumen on testing with heat and acetic acid, and a faint ring with the cold nitric-acid test. Microscopically there were a few epithelial cells, and some crystals of phosphate of lime and urate of soda, but there were neither casts nor pus corpuscles found. After standing for twenty-four hours the urine turned alkaline, which lead me to suspect that the albumen present was, probably, mucous albumen. Excepting the passing of a large quantity of urine containing a small amount of albumen, there were no other symptoms indicating Bright's disease. It may be mentioned that Dr. Louis Bazet examined this man's urine some years ago, and also found a small quantity of albumen, but no sugar.

Syphilis has already been excluded as a cause of shedding of the nails in this case; and there were absolutely no indications of leprosy, nor was the affection of his nails like any of those occurring in leprosy.

Follet's case,¹ above mentioned, of spontaneous shedding of the nails in diabetes resembled the case in hand in many particulars: First, the nails fell off without any inflammatory reaction or pain; second, the finger-nails alone seem to have been affected, and third, the patient's father had had the same affection. There are, however, marked differences between the cases. In Follet's case the woman, who was twenty-six years of age, had had the affection only a short time, and it had not accompanied her throughout life, as in the case under consideration. Then, again, in Follet's case, the patient had glycosuria, and she said that her father had died of diabetes a short time after his nails had begun to fall off, and it was, in fact, on account of fear of death or of a grave issue that she consulted Follet in regard to her nails.

Castaret has lately published a case of painless, non-inflammatory spontaneous shedding of the finger-nails which, however, differs in some important particulars from the case we are now considering.² In Castaret's patient the affection had only lasted a short time, not from birth. The detachment of the nail from its bed commenced under the free edge of the nail, and spread backward, and the detachment was due to a tumefaction of the nail-bed that raised the nail up like the insertion of a wedge. Nicolle and Halipré's cases of hereditary disease of the nails differed in many respects from the case under consideration, for in their cases the nails were discolored, thickened, and rough, and there was a marked tendency to periun-

¹ *Bulletin Médical du Nord-Est*, 1873, p. 351, cited by Bonieux (vide supra).

² "Alteration des Ongles d'Origine Inconnue (Decollement Spontané)," par M. Castaret, *Annales de Dermatologie et de Syphilographie*, 1896, page 1419.

gual inflammation, and in many members of the afflicted family the hair, as well as the nails, was affected. In the present case there was no dystrophy of the nails, and the hair was strong, and well supplied with pigment.

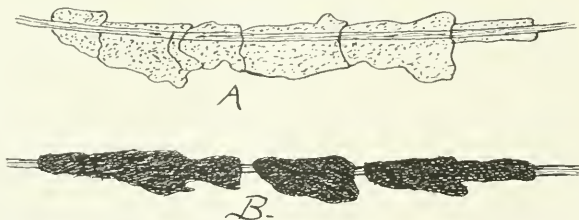
A PECULIAR AFFECTION OF THE HAIR-FOLLICLE.¹

By JOSEPH GRINDON, PH.B., M.D.,

Professor of Dermatology, St. Louis Medical College; in charge of Skin Departments, O'Fallon Dispensary and Out-Clinic, St. Louis Mullanphy Hospital; Consultant to Missouri Baptist Sanitarium, and to Protestant Hospital, East St. Louis, Ill.; Member American Dermatological Association.

IN January, 1894, I was consulted by a young lady for an affection of the scalp. At that time I made the following note: "Miss H., aged 15. Brunette, general health excellent. Just within the hairy margin, in front of each ear, over an area measuring 1 x 2 cm., is a reddish, slightly scaly, slightly itchy patch. Many of the hairs growing from these patches present along their length peculiar beaded concretions, grayish white in color, and to the casual glance closely simulating the ova of the pediculi. Under a low power they look like casts of inspissated sebum and are from three to five times the diameter of the hair shaft, which they completely enclose like a sleeve. They do not dissolve in ether, but

FIG. 2.



Leitz, oc. 1, obj. 2. Lower figure shows appearance after treatment with ether.

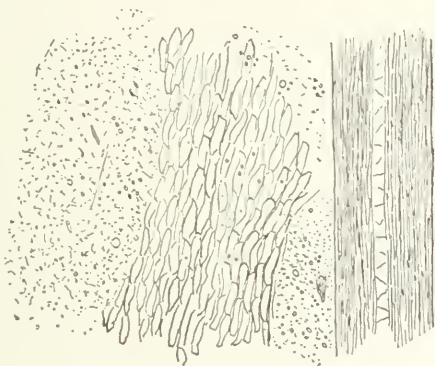
shrink and become opaque. (Fig. 2, *b*.) The hairs in this region come out with little traction and no pain, bringing with them the sheath in most instances. Here and there the mouth of a follicle is dilated and harbors a comedo-like plug, which is easily removed. Epilated and ordered a resorcin ointment, 1 to 15."

Patient made a few more visits and the trouble having apparently disappeared, she was lost sight of for the time.

¹Read before the American Dermatological Association, Washington, D. C., May, 1897.

In January, 1897, she returned. The trouble had reappeared over the same sites, but the affected areas measured about three cm. each way. Patient stated that the hairs, epilated three years before, had never grown out again, and that others in the neighborhood had dropped out. There were, in fact, but few hairs over the involved areas. These, however, as well as those at the margin of the patch, were quite firmly implanted, some breaking off in the effort at epilation. Some of the marginal hairs presented the same nit-like masses which had before attracted my attention. The masses were less numerous and smaller than those seen three years before, of less diameter, and rarely more than two on one hair, placed four to six cm. apart, whereas before four or five could be

FIG. 3.



Leitz oc. 4, obj. 4. After soaking in KHO sol. In mounting, the hair slipped out sideways from the mass.

seen in immediate juxtaposition. The scalp at these sites looked normal, except for a minute pink areola about the hair-follicle. The itching had disappeared.

A new patch one cm. in diameter is seen at the frontal margin near the median line. The hair everywhere is lustrous and wavy, and showed no splitting at the ends. General health of the best. Epilation was practised, and a salicylic ointment, 1 to 30, rubbed in. After three months the case seemed cured. New, firm hairs are growing in over the denuded patches. At no time was there any sign of pustulation.

A number of the little masses were treated with potassa solution and examined. They consisted of an inner and an outer layer. The inner layer showed, occasionally, next the hair, a few polygonal nucleated cells of the inner layer (Huxley's) of the internal root sheath

(root sheath proper). Most conspicuous, however, were the non-nucleated fusiform cells of the outer fenestrated layer (Henle's). Outside of these was a mass of amorphous detritus containing oil globules and granules.

Fig. 3 shows the appearance under a high power. In the process of mounting the hair slipped out of the root sheath and the outer layer of the internal root sheath is shown lying to one side of it, with the above-mentioned mass of detritus surrounding it.

Some specimens treated with a simple stain showed a few elements of a streptococcus chain, probably accidentally present. The Gram method showed no organism retaining the stain.

The affection, therefore, consists of an inflammation of the hair-follicle characterized by extrusion of the cells of a portion of the root sheath proper *en masse*, which remain threaded over the hair, and are carried up with it in its growth, the process being repeated from time to time until successive masses, bearing a superficial resemblance to nits, are strung along the hair. It is accompanied by a slight redness about the follicular orifice; is chronic in character, and results in curable alopecia.

The only allusion to this condition which I have found in the course of my reading is a reference in Crocker's work, p. 621, to Beigel, "Diseases of the Hair," p. 111, where is mentioned a "nodular disease of the hair of the head, due, he thinks, to a disease of the hair-sac, the nodules being composed of compressed cells, like those of the inner root sheath." Unfortunately, I have not had access to Beigel's work.

Possibly Erasmus Wilson¹ adverts to the same condition in his description of *narcosis folliculorum*, which, he says, "is far from being uncommon." "The scalp and hairs are found covered with . . . an admixture of granular particles and furfuraceous scales. Masses of this granular substance are collected at the mouths of the follicles, while others are threaded like beads upon the hairs." There were no granular particles nor scales on the scalp or hairs in my case.

The affection presents a superficial resemblance to several clinical conditions from which it should be distinguished, and which may be here enumerated.

As has been already mentioned, the appearance of grayish white masses, of the general contour and sometimes almost exact size of the ova of pediculi, strung along the hair, might lead a careless ob-

¹ "Diseases of the Skin," sixth American edition, p. 632.

server into the diagnosis of head-lice. Even with the naked eye, however, it can be seen that the little bodies are strung bead-like over the hair, and not merely attached to it at one end.

The diagnosis from trichorrhesis nodosa is similarly easy, requiring at most the use of a pocket-lens. This disease, by the way, also at times simulates the presence of nits. The mass does not taper off at the ends, and there is no fraying out of cortical bundles nor brush-like appearance.

The same may be said of Monilethrix; beaded hairs; the *aplasie moniliforme* of Hallopeau and Lefèvre.

Hodara's disease,¹ the trichorrhesis of Constantinople, is characterized by very small nodes, all situated toward the tip of the hair, and accompanied by splitting of the hair.

The term tinea nodosa is often used as synonymous with trichorrhesis nodosa. Morris and Cheadel², however, applied the name to a growth found on the beard of a young man. The nodes were composed of granular material and ascribed to a fungus.

Allied to the last is Giovannini's disease,³ in which small nodes appeared on the patient's mustache. They consisted of masses of spores with mycelium.

Piedra, which also is said to resemble the ova of pediculi, presents small nodes differing from those of the affection under consideration, according to the descriptions in text-books, by their hardness, gritty feel, and dark color, by the peculiar rattling sound to which they give rise when the hair is combed or shaken, and by the fact that hot water will remove them. Furthermore, its habitat is virtually restricted to the United States of Colombia.

In trichomycosis nodosa, leptothrix, or Paxton's disease, the concretions extend for a distance along the shaft and are limited to the scrotal and axillary hairs, being usually of a yellowish color in the former situation, and orange or red in the latter, from the presence of the bacillus prodigiosus.

Chignon fungus, Beigel's disease, exhibits nodes strung along the hair shaft, but is found only on the false hair of that fortunately defunct abomination, the chignon. It is a botanical curiosity and not a disease.

If a name for this condition were desired it might be called eccholic folliculitis, from the fact that the mass of cells is thrust out.

509 N. Theresa avenue, St. Louis.

¹ Menahem Hodara, *Monatsh. f. Prakt. Derm.*, August 15, 1894.

² *Lancet*, 1879, vol i, p. 190.

³ Sebast. Giovannini, *Vierteljahresschrift f. Derm. u. Syph.*, 1887.

A CASE OF FATAL GONORRHEAL INFECTION, WITH
AUTOPSY REPORT.¹

By GEORGE EMERSON BREWER, M.D.,

Attending Surgeon, City Hospital; Assistant Demonstrator of Anatomy, College
of Physicians and Surgeons, New York.

THE following case, which recently came under the writer's observation, was thought to be of sufficient interest to justify its presentation to this Society.

W. L., aged fifty-two, single, called upon the writer on October 3, 1896. He stated at the time that he had contracted an acute gonorrhea some six weeks previously while traveling in Europe. He had been under the care of several prominent medical men on the Continent and in England, and at the time of his visit complained only of a slight mucopurulent discharge, and a moderate amount of vesical irritation. Examination at the time showed the evidences of a subacute anterior and posterior urethritis, with tenderness over both seminal vesicles, and slightly tender points in the prostate. No evidences of disease of the kidneys, bladder, or testicles. His treatment consisted in urethral irrigation, the passage of sounds, and instillations of nitrate of silver in the deep urethra, with gentle massage of the prostate and vesicals. In about ten days his condition had improved to such an extent that he went to his home in Connecticut. Having no discomfort of any kind, he gradually resumed his duties and remained apparently well for ten days. At this time he noticed a return of the vesical irritation, which rapidly became extremely painful, and was accompanied with fever, pain in the rectum, and great dysuria. He came at once to New York, and upon his arrival was found to have a temperature of 101° F., pulse 100. He was passing urine with extreme pain every few minutes. The stream was small and the urine cloudy.

Rectal examination revealed the presence of a tender, hot, and enlarged prostate. He was sent to bed, his perineum blistered, hot rectal enemata and morphine suppositories ordered, and a calomel purge given. The following day his painful symptoms were less acute, owing to the morphine, but the prostate was larger and more tender. After a consultation with Dr. Swinburne a statement of his condition was made to the patient and an operation advised.

¹ Read before the Section on Genito-Urinary Surgery, New York Academy of Medicine, May 11, 1897.

To this he readily consented, and after shaving and disinfecting the perineum, ether was given to complete surgical anesthesia.

With the patient in the lithotomy position, a curved incision with the convexity upward was made, extending from one tuberosity to the other, and about three-fourths of an inch above the anus. The tissues were divided layer by layer until the dense fibrous capsule of the prostate was reached. This was punctured in the most densely indurated spot with a blunt probe-director and pus reached. A pair of dilaters were then introduced and the opening enlarged sufficiently to admit the finger. About two drams of creamy pus was evacuated, the cavity irrigated and packed with sterilized gauze. The wound was partly united with sutures, but a central opening of about three inches was left, through which the packing protruded.

The operation was followed by immediate relief of all the painful symptoms; the patient passed a fairly comfortable night, and on the following day was able to retain his urine for two or three hours. The temperature gradually fell to normal; the enlarged and indurated prostate gland rapidly diminished in size, and at the end of ten days was no longer tender, and but little, if at all, larger than normal. The first dressing was removed on the second day, and a small drainage-tube substituted for the gauze packing. The wound rapidly granulated from the bottom, and was solidly healed in three weeks. On November 10th, the temperature having been practically normal for fourteen days, and the wound reduced to a small granulating area, the patient was allowed to sit up for two hours, which he did without discomfort. After his return to bed he experienced pain in the left leg, which began to swell rapidly, with a tender and indurated point over the upper part of the femoral vein. He was seen in consultation at this time by Dr. Walter B. James, who agreed in regarding the condition as one of femoral thrombosis, with a favorable prognosis. The temperature ranged for two or three days between 99 and 100°, then again fell to normal. The pain gradually disappeared; the swelling, which was never excessive, slowly diminished, and on November 21st the measurements of the two legs were the same. From this time his condition improved rapidly; his temperature remained normal. His appetite was keen, his sleep perfect, and he complained of no discomfort. The wound had entirely healed. The urine was clear and was voided at regular intervals, without pain or abnormal sensation. Repeated examinations failed to reveal any tenderness or induration of the prostate or pelvic diaphragm. He begged to be allowed to

sit up, and was only kept in bed as a matter of extra precaution on account of the recent thrombosis.

On November 27th, thirty-two days after his operation, without the slightest attributable exciting cause, after a hearty Thanksgiving dinner, his temperature suddenly rose from normal to 104° . The following day it reached 105° , but without the slightest sign or symptom of anything abnormal in the urinary organs. He was again seen in consultation by Dr. James, who detected a small patch of pneumonia in the lower lobe of the left lung. On December 1st, three days after the sudden rise in temperature, the right leg began to swell, and this was also accompanied by a tenderness over the femoral region. From this time his symptoms became progressively more grave; his appetite diminished; he rapidly emaciated; his mind became confused; he became progressively weaker, stupid, and cachectic. The tongue, mouth, and gums became dry and crusted. He slept but little and had occasional sweats. Repeated examinations of the chest failed to reveal the evidences of enough pneumonia to account for the markedly septic condition into which he had fallen. The temperature was irregular and ranged between 102 and 105° F. The pulse became more rapid and weak, and on December 19th, twenty-two days after his sudden rise in temperature, he died.

The autopsy was made by Dr. John B. Thatcher, Pathologist of the Presbyterian Hospital, who submitted the following report:

"At the autopsy the pyemic condition was shown by the pressure of numerous small abscesses in each lung, and an abundant sprinkling of very minute abscesses in both kidneys. The left common iliac, external iliac, and femoral veins were filled with a firm red thrombus. The right common iliac, femoral and internal iliac, with some of its branches deep in the pelvis, contained soft thrombi and some puruloid matter. The prostate showed no lesions, but about the right seminal vesicle were appearances of previous inflammation.

"Microscopic examination of sections of the kidney showed radiating streaks of intense inflammatory infiltration, containing large colonies of staphylococci. Outside of these streaks there were very slight inflammatory changes. The lungs showed a good deal of diffuse inflammation, and some spots where the inflammation was intense, staphylococci, streptococci, and bacilli were found in the sections.

"Sections of the left femoral vein showed it to be almost completely filled by the thrombus. In places it was slightly separated

from the intima, partially organized, and to a moderate extent canalized by small blood-vessels. Cultures from lung, spleen, kidney, and prostate, showed pure growths of staphylococcus pyogenes aureus. Cultures from the thrombus, in the left femoral vein, also showed the staphylococcus pyogenes aureus, and in addition some coarse bacilli, evidently due to accidental contamination."

From a careful review of the clinical history and autopsy in this case, it seems probable that we had to do, in the first place, with a subacute gonorrheal seminal vesiculitis on the right side, before the occurrence of the acute prostatitis. That during the acute attack this vesicle became infected with pyogenic organisms, which, however, remained latent for several weeks, until the complete subsidence of the prostatic inflammation. That the left femoral thrombosis was due to an infection which was active enough only to give rise to the coagulation of the blood, but not sufficient to produce systemic infection or to interfere in any way with the natural processes of repair, which were shown at the autopsy to be well under way. That the infection of the left internal and common iliac veins was direct from the diseased vesicle on that side, and that the micro-organisms in this instance were virulent enough not only to produce thrombosis, but to give rise to the infected and broken-down clot, through which the general systemic effusion took place.

NOTES ON THE STATUS OF COLLES' LAW, WITH REPORT OF A CASE.

By WILLIAM THOMAS CORLETT, M.D., L.R.C.P.,
London;

Professor of Dermatology and Syphilology in Western Reserve University;
Dermatologist to Lakeside and Charity Hospitals,
Cleveland, O.

IN his "Practical Observations on the Venereal Disease," published in London in 1837, Abraham Colles of Dublin wrote "I have never seen or heard of a single instance in which a syphilitic infant (although its mouth be ulcerated), suckled by its own mother, had produced ulcerations of her breasts; whereas, very few instances have occurred where a syphilitic infant had not infected a hired wet nurse, and who had been previously in good health. It is a curious fact that I have never witnessed nor ever heard of an instance in which a child, deriving the infection of syphilis from its parents, has caused an ulceration in the breast of the mother."

Numerous observers having an extensive field for clinical study

have confirmed Colles' statement, and have honored his memory by naming it Colles' Law.

That exceptions to the law occur is denied by many, while others believe its validity to be a matter of doubt. From analogy one might look for an occasional exception to the rule without detracting from its value as a clinical fact. It would be a matter of surprise if an occasional vaccination did not fail to protect against variola, even after a successful inoculation of the protecting virus. That immunity from rabies is infallible, is hardly claimed by its most enthusiastic advocates. Colles' law holds good, I believe, but that there is an occasional exception seems warranted from trustworthy data at our disposal.

Among the most recent may be mentioned the following, reported by L. Merz,¹ which seems to be complete in every detail:

A man thirty-four years old contracted syphilis at twenty-nine which was of a mild type. Three years later the disease revealed itself by an outcrop of mucus patches in the mouth, which was two months after his marriage. His wife became pregnant six or eight months later. She went to full term and was delivered of a boy in October. The child appeared well and was fully developed. He was nursed by the mother. At the end of fifteen days there appeared on the lips, tongue, and cheeks of the child mucus patches, and a discrete pemphigus on the legs and hands. The mother was put on the mixed treatment, with a disappearance of all manifestations on the child at the end of ten days. One month from this time a painful fissure appeared on the left breast of the mother, which proved to be an indurated chancre with indolent adenitis of the glands in the axilla. The ulceration healed in fifteen days and was followed in thirty days by a roseola with falling of the hair, and mucus patches on the inside of the right cheek. The treatment which was given at the time of the outbreak in the child, was pushed more vigorously. No other manifestations occurred, and both mother and child finally appeared free from the disease.

Violi² of Constantinople, relates a case in which the father was syphilitic and the mother free from the disease until after nursing her syphilitic child, when there appeared a sore on the nipple and later a general syphilitic eruption.

Sturges, in "Morrow's System of Syphilology," after detailing in

¹ L. Merz, *Bull. Med. de l'Algerie*, November 1, 1889; abstract in *Annales de Dermatol. et de Syph.*, 1890, p. 532.

² Violi of Constantinople. "Transactions First International Congress of Dermatology," Paris, 1889, p. 701.

full two cases, adds: "We must suspend judgment upon the truth of Colles' law, which we have hitherto accepted, and admit that it may be possible that a diseased child can infect its sound mother, and if that be accepted, we are forced to admit, as a corollary, that a healthy woman, one free from syphilis, can give birth to a syphilitic child."

Coutts (*London Lancet*, June 9, 1894, p. 1443), during a period of ten years at the Shadwell's Children's Hospital, in which fully 2000 cases of congenital syphilis were seen, met only one instance in which a mother was affected by her syphilitic child. The history of this case is not complete as no evidence of syphilis in the father could be established; in fact, he gave no evidence of ever having been infected.

Ogilvie¹ has collected the published reports of about twenty cases in which the law of Colles was not borne out.

The clinical truth is probably more accurately expressed by Raumès (1840): "It is observed that a mother having carried in her womb a syphilitic child infected by the sperm of the father, does not on nursing it contract the disease so readily as would be the case were a strange nurse employed." Without entering into a discussion as to the cause of this immunity, permit me to report a case of interest in this connection.

A woman applied at Charity Hospital for an extensive eruption on her baby, when it was discovered that there was also a suspicious lesion on her own breast. The case could not be admitted, but was referred to the clinic at the medical school where she appeared a few days later. My notes of the case are as follows:

January 11, 1897, Mrs. J. N., aged thirty-eight, presented her child, aged two months, with a dark reddish macular eruption distributed over the entire body including the palms and soles. The lesions varied from a split-pea to a half-dime in size, in places tending to become scaly, while on the buttocks quite extensive excoriations were present. The baby had snuffles, was shriveled, and had mucus patches in the mouth. The mother said the child was born at full term, was well developed, nursed at the breast, and remained well until three weeks old, at which time she noticed a slight reddening of the skin about the genitals followed by the formation of blisters which soon ruptured, leaving raw places. (These were still present.) About this time the child snuffled from a supposed cold in the head, and the general eruption appeared. There was no doubt as to the diagnosis of syphilis.

¹ Ogilvie, *London Lancet*, February 1, 1896.

The mother was anemic with a faint greenish or muddy tint, and complained of a slight aching in the bones of the legs. There was a sore on the left breast about two inches from the nipple, which, as nearly as she could tell, appeared about a fortnight after the baby's mouth got sore. In shape the lesion looked like a superficial ulcer, with a saucer-shaped base, and prominent, clearly defined margin. It was somewhat larger than a split-pea in size, was indurated, and covered with a slight serous discharge. It was tender when grasped between the thumb and finger, but otherwise gave rise to no pain. The axillary glands in the corresponding side were indurated, freely movable and painless. The post-cervical lymphatic glands were also enlarged. There was redness of the fauces which was attributed to a slight cold. No other lesions were found in the mouth. The skin was free from scars or other evidences of syphilis aside from the one described. Thus far in the evolution of the disease it pointed unmistakably to syphilis contracted from the child.

The mother's previous history was as follows: She had always enjoyed good health, had borne two healthy children, still living, by her first husband, and had never miscarried. She was married a second time one year ago and the baby at her breast was the outcome of this marriage. Her second husband, the baby's father, had previously had four healthy children by his first wife, all living, the youngest being about six years old. After the death of his first wife he had remained single about three years when he married the woman who now applied for treatment. The patient further said her present husband had been under treatment for some unknown malady since their marriage, although he appeared well and often took medicine for a "cold." She had never seen any breaking out on him nor other evidence of disease.

The child was given mercurial inunctions, and the mother the tincture of gentian, and directed to return at the next clinic. An effort was made to see the husband, but without success. As the patient did not appear at the time appointed, four days later, an assistant called at their home and found they had suddenly departed to parts unknown. Later they were traced to Cincinnati, but not one of the medical gentlemen with whom I have communicated has been able to throw further light on the case.

Thus the history is incomplete and is not offered as a convincing instance of the refutation of Colles' law, although I believe the mother was infected from her child and that the sore on her breast was the initial lesion of syphilis.

Clinical Notes.

AN EMERGENCY RETENTION CASE.

By E. DEL. BRADIN, M.D.,

Newark, N. J.

THIS case is designed to meet the requirements for the relief of retention of urine due to obstruction either from stricture or prostatic enlargement. When retention is due to atony, over-distention from neglect to empty the bladder at the proper time, or any similar cause, the physician's task is one of simple catheterism, and provided he employs only clean instruments and rejects "the sweet oil" and "pure vaseline" offered him by some well-meaning member of the household, he can promptly relieve his patient by a clean, soft-rubber catheter and save him from

FIG. 4.



septic trouble in the future. It must not be understood that all the instruments in the case are intended for any given case of retention. These cases often receive too energetic treatment either from motives of misplaced kindness, or from ignorance. Better by far had the physician left his catheters at home than to submit his patient to the prolonged and oftentimes useless efforts at catheterism, when by opiate, hot baths, and rest in bed he would be relieved painlessly in a few hours.

But, when it is deemed necessary to enter the bladder and relieve the retention as speedily as possible, either by catheterism, external urethrotomy, or by puncture above the pubes, the means are at hand and the physician will not find it necessary either to go

or send to his office for appropriate instruments for performing any of these operations.

Should the case be one of stricture, the first step would be to render the anterior urethra aseptic. By means of a small velvet-eyed clean catheter inserted in the canal and attached to the syringe filled with antiseptic fluid, this is accomplished. The same, or a smaller catheter, is then passed into the bladder; failing in this, a guide, either filiform or whalebone bougie, should then be tried.

By an ingenious attachment to the syringe the entrance of the guide into the bladder can be facilitated by forcing the lubricant along with the advancing guide. Another valuable means of introducing the guide is Eldridge's Pathfinder. The instrument is passed down snugly to the face of the stricture and held firmly, when one guide after another is passed through it, until one of them engages in the opening. External urethrotomy then becomes a comparatively simple procedure. (Fig. 5.)

FIG. 5.



Should no guide be made to pass, and external urethrotomy without a guide be deemed inadvisable, the bladder can be punctured above the pubes and emptied of its contents by means of the aspirating syringe attached to an aspirating needle, and the patient given opium to quiet his nervous and excitable condition, when in a few hours he will have the gratification of feeling urine trickle from the meatus. A guide can then almost certainly be passed and the operation performed, if thought necessary.

If the cause be due to enlargement of the prostate the instruments usually employed for this form of obstruction are accessible. The ones most commonly employed are Mercier's invaginated

FIG. 6.



catheter, his elbowed and crutched catheters of various sizes; Thompson's prostatic catheters, sizes 9, 11, 13, 15, and 17 F., made

of virgin silver, so as to be bent at any curve. Otis guide is also another valuable instrument for the introduction of a catheter into the bladder. The syringe, through the ingenuity of Messrs. G. Tiemann & Co., is adapted for several purposes. By an attachment to a conical hard-rubber nozzle, it will fit a catheter of any size, in order that the anterior part of the canal may be cleansed before any following

FIG. 7.



instrumentation. By means of a two-way stopcock the syringe can be converted into an aspirator, and the bladder emptied by this method, and immediately washed through the canula over the pubes. The attachment for introducing the guides has been already mentioned. Through the valuable suggestions of Mr. Stohlmann, of George Tiemann & Co., nothing has been omitted and nothing superfluous enters into it.

The case is compact, light, and provided with means of making aseptic any instrument intended for use. It contains an air-tight

FIG. 8.



jar for a carbolized lubricant, as well as a space for antiseptic tablets, needles, and silk, etc. Called hurriedly to these cases, the physician need not resort to the usual abominable practice of stuffing a few dirty catheters into his pocket and start on a journey of destruction rather than of relief.

I have said nothing about internal urethrotomy as a means of relief of retention, as I think the cases are extremely rare in which it is appropriate. If decided upon, Cameron's stricture-cutter, with filliform bougie attachment, Civiale's urethrotome, and Thompson's rapid dilator, tunneled, size 12 F., form a part of the case.

No originality is claimed for any instrument contained in the case—they all bear the names of the eminent men who devised them. For my own convenience I have collected them, and through

the admirable manner in which Messrs. Tiemann & Co. have carried out my ideas, I no longer feel that I am only partially equipped when sent for to relieve retention of urine.

Considering the comfort derived from the knowledge that we are fully prepared for any emergency in these cases, the cost of the case is trifling.

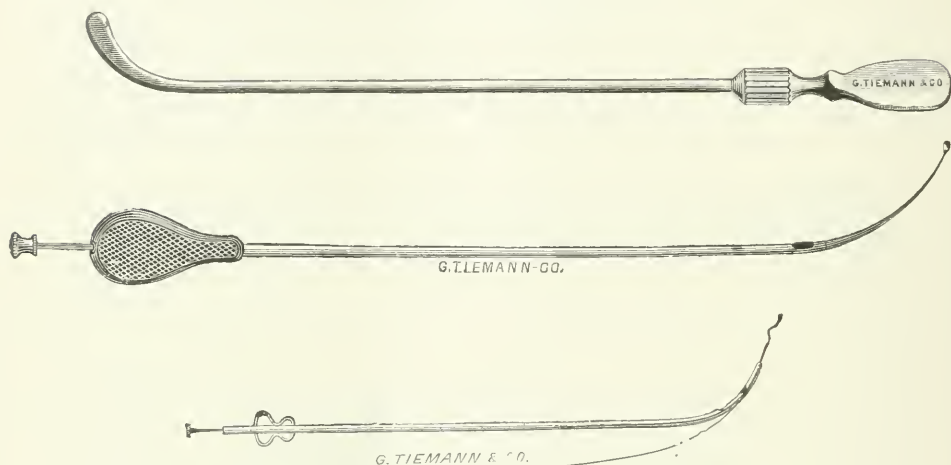
The instruments contained in the case are the following:

Thompson's prostatic catheters, 9, 11, 13, 15, and 17F.

Thompson's retention catheter.

Thompson's stone searcher, with attachment fitted to phonendoscope.

FIG. 9.



Thompson's rapid dilator, with filliform attachment.

Gouley's catheter staffs, tunneled, 7 and 14F.

Mercier's invaginated catheter, his crutched and elbowed catheters, sizes from 5 to 18. Soft-rubber catheters of various sizes. Delicate stricture cutter, with filliform attachment.

Civiale's urethrotome. Gouley's flexible director probe and a fine scalpel. Knives for external urethrotomy, needles, silk, probes.

Otis guide. Eldridge's pathfinder. Whalebone guides and filliform, long and short, with attachments.

Malley's exploring bougie, graduated.

Hard-rubber syringe (three-ounce), with attachments, for washing the urethra, for lubricating guide, and for aspirating bladder.

Two aspirating needles, jar for lubricant, card scale.

2 Gouverneur street.

A BEAN AS THE NUCLEUS OF A CALCULUS.¹

By L. J. KROUSE, M.D.,

Cincinnati.

MR. G., aged about twenty-four years, an American by birth, has been suffering since November 7, 1896, from bladder trouble. Says that for some time previous to that date he had been drinking pretty freely. Always enjoyed good health. He came to Cincinnati on account of this trouble, which had previously been diagnosed by his local physician as stone in the bladder. Thompson's searcher was used and a foreign body could easily be detected, but no distinct click could be elicited. A cystoscopic examination was then made, with the result that a stone was found in the bladder. The stone was located on the left side

FIG. 10.



Four-fifths natural size. One-half of the bean is in upper part of the photo. Several fragments are in lower part.

of the viscus, a little above the trigonum. It seemed to be adherent to the mucous coat, and its outline was frequently obscured by a floating mass, which every now and then passed between the calculus and the cystoscope.

This case seemed to be an ideal one for litholopaxy, nevertheless, on February 22, 1897, median lithotomy, which subsequently proved to have been the better operation, was performed. In its removal the stone broke into numerous fragments. The exterior, or shell of

¹ Presented to the Cincinnati Academy of Medicine, March 29, 1897.

the stone, was composed entirely of lime salts, while the interior, or nucleus, was the bean. The nature of the bean could not positively be determined; it reminded one very much of the appearance of a large lima bean or that of a peanut. The dimensions of the bean (in its swollen condition) were about one inch in length by seven-sixteenths of an inch in thickness. The stone weighed over 110 grains. The husk of the bean, which was not adherent to the body of the bean, separated the nucleus from the external shell of the stone, and as a consequence the two parts of the stone separated as soon as the stone was broken.

Many obscure facts have been cleared up since the character of the calculus was made out. Firstly, the reason why a distinct click could not be elicited on striking the stone with the searcher; and, secondly, the reason why the foreign body, instead of lying loose in the viscus, was found adherent to the bladder wall. No doubt slight adhesions were formed between the bean and the mucous membrane before the deposit of lime salts took place.

In regard to the after-treatment of this case, a large rubber drainage-tube was introduced and allowed to remain in the bladder for over a week; daily irrigation with hot sterilized water was instituted (the patient being in the sitting posture), so as to wash out any portion of the foreign body which might otherwise have remained in the viscus. And it seemed that this treatment was of benefit, as several pieces of bean came away some days after the operation.

20 West Seventh street.

A CASE OF IMPETIGO SIMPLEX.

By FRANKLIN JNO. KAUFMAN, M.D.,

Syracuse, N. Y.

SOME authorities deny the existence of impetigo simplex, described by Duhring. A few days ago I was called to see a typical case in a female child four days old. The child was otherwise normal and weighed about eight pounds. There was no history of impetigo contagiosa in the family or immediate neighborhood. I found about a dozen straw-yellow, firm, discrete, elevated, thick-walled, semi-globular pustules, about the size of a finger-nail, surrounded by a pronounced dark red areola, and scattered over chest, abdomen, and legs. There was no depression or umbilication in any of the pustules. They did not form in groups or coalesce, and the surrounding tissue was not infiltrated. When new lesions

formed, they formed as pustules without any intermediary stage. After seven or eight days the contents of some of the pustules became slightly bloody and then dried to yellowish or brownish crusts, fell off and left no scar except a slight reddish spot which faded in a few days. The disease did not seem to distress the child in any way; it nursed and slept as well as any normal child. When the pustules were broken before they reached maturity they refilled. Microscopical examination of the contents of a pustule showed many agglutinated pus-corpuscles, a few red corpuscles, pus-cocci, and broken-down epithelial cells. The disease lasted about four weeks, and the child appeared to be in better condition than when I first saw her.

Treatment.—Carbolated zinc oxid ointment and a protecting covering of absorbent cotton.

Book Reviews.

Protozoan and Blastomycetic Infection of the Skin. By T. C. GILCHRIST, M.D. Reprinted from the Johns Hopkins Hospital Reports, Baltimore.

While Sabouraud in France is revolutionizing accepted ideas of alopecia and the seborrheas, Gilchrist is doing the same in America for this vexed question of protozoan infection. The parallel is exact; one is as new and as striking as the other but the advantage remains here, for while certain steps in Sabouraud's processes are wanting, Gilchrist's work is complete—at least it seems so in the present state of our knowledge.

The first of the five monographs composing the volume is devoted to two cases of protozoan disease, in which proof of the presence of coccidia does not rest on differential staining but on conformation with Koch's laws. Inoculations upon animals were abundantly successful, being made from organisms pressed out of the skin lesions and cultivated on artificial media. The pathological change is described as being that of typical tuberculous nodules. In addition to an epidermic hypertrophy, there are miliary abscesses scattered through the corium (the organisms themselves are apparently pyogenic), masses of granulation cells, giant cells, and numbers of protozoa scattered through epidermis and corium, singly or in groups. The disease rarely invades the subcutaneous tissue. The parasite, itself, when grown, is spherical and shows a double-contoured capsule. A clear layer, refractive and staining with difficulty, underlies this. The center is finely granular and stains readily. Reproduction is by sporulation, the number of sporozoites from one parent organism varying, but usually large, twenty or more. They are freed by bursting of the capsule. Numerous photomicrographs present the appearance of the parasite which are fair in the main, more than

can be said of the reproduction of the clinical features of the disease. It is hardly worth while to describe the latter, as the finding of the organism makes the diagnosis, but it may be said that protozoan disease proper is a chronic, ulcerating, at times fungating affection, advancing peripherally and bearing a close resemblance to lupus verrucosus. It is rebellious to treatment, and resulted fatally by involvement of the system generally in both cases.

Blastomycetic dermatitis forms the subject of the second paper. An abstract of the author's findings has already appeared in these pages (November, 1896) and, we are glad to say, they will be enriched by the complete report of his two cases, later. The parasite, vegetable and multiplying by budding, offers an instructive contrast with the animal organism just described.

Important as the first two are, the third monograph is the one of greatest interest. Dr. Gilchrist has driven the last nail in the coffin of the obsession which has taken possession of so many expert pathologists, the coccidial theory of the origin of cancer, psorospermiosis, herpes zoster, and molluscum contagiosum. Darier himself deserted his theory last year as regards the second in the list, but a host of opponents are left. In the light of the cases he had the privilege of studying, the author has no trouble in pointing out conclusively that the "bodies" in all of them are anomalies of keratinization, and that, if parasites are to be found, it will not be among the protozoa. All the careful work, such as Ruffer's, for instance, bestowed on the problem, has not been wasted for the limits of knowledge of pathological processes in the epidermis have been extended in a way it would never have otherwise been. If valuable for nothing else, the bibliography of sixteen pages makes the work indispensable to the dermatologist.

The fourth paper treats of two cases of molluscum fibrosum and their pathology. The author agrees with other investigators that the structure is of embryonic connective tissue, easily degenerating into a sarcomatous form. The number of varieties seen account for the divergent views held as to their origin. Gilchrist has no new theory to offer, but thinks they are congenital and grow slightly during life.

The last contribution treats of the pathology of dermatitis herpetiformis. The statement is made definitely that the vesicle begins in the upper layer of the corium, just beneath but not in the epidermis. Minute epidermic vesicles are seen later which are continuous, with the larger one below. Leredde's observation as to the presence of eosinophile cells in number in the vesicles and surrounding tissue is confirmed, but Gilchrist is entitled to equal credit in this regard for the investigations were carried on simultaneously and independently. The latter, however, does not insist on the coexistence of eosinophilia in the blood, in fact, does not mention it at all. Attention is called to the possibility of scarring, a sequel which Dr. Duhring himself says he has not seen. Unna's unsupported statement as to the complete absence of leucocytosis is easily refuted. It is difficult to understand how so bold an assertion could have been made by

Unna unless from a deficiency of pathological material. The author's view of the origin of the disease is that it is toxic and not neurotic.

In conclusion, we extend to Dr. Gilchrist our hearty congratulations on what, in our humble opinion and that of many dermatologists and pathologists, is the best work ever done in this field in America.

J. C. J.

Illustrated Skin Diseases. Portfolios 1, 2 and 3. By WILLIAM S. GOTTHEIL, M.D. E. B. Treat, New York: 1896. Price, per part, \$1.00.

This work is a combination of atlas and text-book. Each division is deserving of its measure of praise, but the text is far away the better claimant to recognition. The letter-press is a positive delight and, when bound complete, these folios will make a handsome volume. The anatomy is short with few details, but amply sufficient for the general practitioner. It is evident that the author does not intend to plunge into any controversies but will pursue a safe middle course, the line of least resistance. The chapter on physiology is commendable, particularly the therapeutic section. We are sorry not to say the same of the classification. In the present state of knowledge, any attempt on this point is bound to be more or less unsatisfactory, but few will agree that prurigo is a circulatory disorder; that lichen planus is a superficial, and lupus erythematosus a deep-seated inflammation. Neither is it easy to understand why a class for the parasites was not established. The consideration of functional and circulatory disturbances is a brief but useful epitome.

Notes of reference are conspicuous by their absence.

As to illustration, the photographs and microphotographs, particularly the former, are good, in many cases excellent, but it is hard to divine an object in reproducing variola or a syphiloderm in brown. The little a photograph shows could not be better obscured. Chromolithography may be crude, "an attempt to imitate nature in a few (we have used as many as eleven) striking colors by mechanical processes," and very costly, but in spite of the cost there is no doubt that every dermatologist will prefer such a plate as appeared in these pages in February to a color-photograph in which all shadows are red and a lesion of circinate psoriasis is tawny in one spot, coppery-red in another, without a suspicion of a scale to be seen anywhere. Nature needs the "personal equation" in the shape of the artist's brush in such a case. Only one of the colored plates is good, that of gumma subcutaneum.

J. C. J.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

TWO HUNDRED AND FIFTY-NINTH REGULAR MEETING, HELD ON
TUESDAY EVENING, FEBRUARY 23, 1897.

DR. J. A. FORDYCE, *President, in the Chair.*

A Case for Diagnosis.—Presented by DR. GEORGE T. ELLIOT.

This was the same patient whom he had presented for diagnosis at the previous meeting of the Society. He then stated that when he first saw the patient, he thought the case was one of small papular syphilis, but upon examination of the body he changed his diagnosis, and placed the case in that as yet ill-defined group which includes some cases of universal acne varioloformis acnitis, folliclis, etc. In the discussion of the case at the previous meeting, Dr. Taylor had expressed the opinion that it was one of syphilis. Since then the patient had received twenty-two inunctions of mercurial ointment, of one dram each; they were then discontinued because salivation occurred; in spite of this, no effect was produced on the lesions, and they have steadily increased in number.

DR. ELLIOT said he desired to call particular attention to the manner in which these lesions originate. There is first a feeling of papulation deep down in the cutis; this becomes more prominent and redness makes its appearance. The lesions then remain unchanged for a long time. On the face a few of the lesions have developed a small, superficial pustule, which dried into a crust and left a slight atrophic pigmented spot behind. The disease has now existed about five and one-half months, and in this does not follow the usual course of a small papular syphilide.

DR. R. W. TAYLOR said he still regarded the eruption as an example of the larger form of the small, miliary papular syphilide. The infection in this man, in all probability, dated back six or seven months. He gives a history of having had headaches five months ago, so severe that he was unable to sleep at night. The primary lesion and the roseola that followed it were probably of such an ephemeral nature that they escaped notice. This not infrequently occurs, nor is it uncommon, in a miliary papular syphilide of this kind, to find these small subcutaneous masses, which constitute the syphilitic papule. They are often met with on the face, and you will feel them as little hardened masses of tissue, generally bunched together, and sometimes so numerous as to give rise to considerable distortion of the features, almost producing the condition to which the French have applied the term *leontiasis*.

DR. TAYLOR said that from the man's history, the distribution of the eruption, its improved condition since mercurial treatment had been instituted, and the peculiar appearance of the lesions on the forearms made him feel positive that the case was one of syphilis.

By way of exclusion he could think of no other condition that would give rise to such a symptom as complex as was found here. The speaker also called attention to a number of flat, disk-like lesions, which, when stretched, gave the appearance of a little lardaceous infiltration underneath the skin; such lesions, he said, are not uncommonly met with during the first year of syphilis; in order to get a good idea of them it is necessary to make traction upon them, when one can see the yellowish-looking tissue, which is simply the round-celled infiltration forming the subcutaneous papule. These lesions had disappeared since the man had been put upon mercurial inunctions.

DR. E. B. BRONSON said that when the case was presented before he had felt fairly positive that it was one of syphilis. In view of Dr. Elliot's statement that new lesions were appearing and the old ones were unaffected by specific treatment he was not so positive now that the case was syphilitic. The eruption certainly resembled none of the ordinary syphilides. In a papular syphilide the lesions usually occur in groups, while in this case he had noticed several isolated lesions. The eruption on the inside of the arms did not at all resemble syphilis; still, if we made a diagnosis by exclusion, as Dr. Taylor said, syphilis was the only thing left to us.

DR. A. R. ROBINSON said he entirely agreed with Dr. Taylor's view of the case. A number of instances had come under his observation where the small miliary, papular syphilide failed to disappear under drug treatment, until the patient had been sent to the country and placed under good hygienic surroundings. He did not think that we could always judge of the effects of treatment in such a short space of time as that during which Dr. Elliot's patient had been under observation and under the existing conditions of this case.

DR. S. SHERWELL said if the eruption was not syphilitic, he did not know what to call it. He thought the patient had improved since the previous meeting, although not to the extent that he should have done under active treatment.

DR. C. W. ALLEN said that at the previous meeting he had been quite decided in his view that the case was not one of acne varioliformis. He still held that opinion. Certain of the lesions which were there a month ago had entirely disappeared, while others were very much better. The course of treatment pursued, therefore, rather went to prove the specific nature of the trouble. The speaker advised hypodermic injections in preference to the inunctions.

DR. H. G. KLOTZ said he was not convinced that the case was one of syphilis. The lesions on the face did not resemble a syphilitic eruption. In judging of the effect of mercurial treatment, we should not lose sight of the fact that almost any infection might be favorably influenced by that treatment, at least temporarily. This is not infrequently shown even in tubercular lesions.

DR. F. D. WEISSE said that judging from the improvement that had occurred under treatment, he was inclined to regard the case as one of retrogressive syphilis.

DR. JOHNSTON said that he did not regard the evidence of improvement under inunction as sufficiently weighty to warrant a change from his original opinion that the case belonged to the group of the "nameless granulomata."

DR. S. LUSTGARTEN said the lesions on the face and those on the body showed marked clinical differences. The latter showed in places considerable resemblance to syphilis, while those on the face did not. The difference in the appearance of the lesions might be due to the difference of the soil from which they sprang. The speaker said that while he did not care to venture a positive diagnosis, he was inclined to look upon the eruption as one instance of the rare diseases described by French authors as folliclis, acnitis, probably of infectious origin. He pointed out that many lesions in this case, especially on the arms, start as little nodules in the subcutaneous tissue or the deeper parts of the corium. In proportion to their development upward the symptoms of inflammation become more apparent. The sweat coils as a starting point would explain here, he thinks, the clinical features of the case.

DR. ALLEN asked Dr. Klotz whether he would expect that mercurial inunctions, applied to the body, would affect the lesions on the face in a folliculitis.

DR. KLOTZ replied, saying he certainly would; that even regions remote from the location of the inunctions would be affected. He understood that inunctions are made on the assumption and with the intention that the mercury be absorbed and affect the system generally, and that it may produce its effects on any part or region of the body.

DR. J. A. FORDYCE said that while such a deep development of the lesions was rather uncommon in syphilis, still we might have a syphilide beginning about the sweat follicles and working up.

DR. ELLIOT, in closing the discussion, said that when he showed the case at the previous meeting, he had presented it as one for diagnosis. At that time he had also said that it seemed to him to belong in that class in which are included cases which have been reported as universal acne varioloformis, acnitis, folliculitis destruens, and so on. During the past month the man had been under careful observation. New lesions had cropped out on the face and body, while some had undergone involution by the formation of superficial pustules, drying up into a crust which fell off and left a superficial atrophy, but the great majority had remained unchanged. The speaker said he was positive that the case was not one of syphilis. Since the previous meeting more lesions have cropped out than have disappeared, in spite of the mercurial inunctions. Dr. Elliot said he would continue the inunctions and show the man again at the next meeting.

DR. TAYLOR suggested that Dr. Elliot might apply the white precipitate ointment to the man's face.

DR. ELLIOT replied that that application would cause an acne varioloformis to disappear. He stated that while he was firmly of the opinion that the case was not one of syphilis, yet he was willing

to keep the man on specific treatment for another month and watch its effects.

Cornu Cutaneum of the Glans Penis.—Presented by Dr. A. R. ROBINSON.

The patient was a man about forty years old, with a horny growth, about half an inch in length, projecting from the glans penis.

DR. FORDYCE mentioned a case which came under his observation some time ago, in which half a dozen growths, similar to this one, sprang from the glans penis. The horns disappeared spontaneously, leaving a perfectly normal skin.

DR. TAYLOR said he remembered seeing the case referred to by Dr. Fordyce. In his opinion those were not true horns, but digitate warts, which may form the starting point of a true horn, like that in Dr. Robinson's case.

DR. ROBINSON, in closing the discussion, referred to the rarity of these horny growths on this part of the penis. One case has been reported in which the growth attained a length of one and three-quarter inches.

A Case of Syphilis Vegetans.—Presented by Dr. J. C. Johnston.

The patient was a woman with syphilitic lesions of an unusual character. On the right foot she had a group of superficial gummata, and on the left leg a number of ulcerative lesions.

DR. ALLEN said that some time ago he had under his care a case of syphilis with gummatous lesions on the foot, very similar to those in Dr. Johnston's case. They proved very obstinate, in spite of both local and general treatment, and several relapses occurred.

DR. SHERWELL said he had seen similar lesions around the buttocks in an elderly lady, which were very slow in disappearing.

DR. TAYLOR said the tuberous, vegetating growths, on the right foot of this patient were not essentially syphilitic, although we call them the vegetating syphilide. They are the result of a form of inflammation which often follows in the wake of syphilitic ulcers and gummatous lesions, sometimes giving rise to a bastard form of elephantiasis. They are usually very intractable to treatment. Applications of mercurial ointment and bandaging, even with plaster-of-Paris bandages, often produce only fair results.

DR. LUSTGARTEN said he agreed with the previous speakers regarding the obstinacy of these cases. While the lesions are usually classed as syphilitic, he doubted their syphilitic nature and pointed out their resemblance to certain forms of sarcoma, or as called by Kaposi, sarcoid tumors.

DR. KLOTZ said he agreed with Dr. Taylor that these cases are more of the character of elephantiasis. Local applications produce the best effects. He advised strapping the lesions with mercurial plaster.

DR. FORDYCE thought the condition was due to a secondary infection engrafted on a syphilitic lesion. He advised curetting the lesion and then applying a mercurial preparation.

DR. JOHNSTON, in closing the discussion, said he intended to treat the case surgically. He stated that the patient was exceedingly filthy

and he was inclined to agree with Dr. Fordyce that the condition was due to a secondary infection on a syphilitic basis.

A Case of Tubercular Osteomyelitis.—Presented by DR. J. A. FORDYCE.

The patient was a young man, eighteen years old, who was suffering from a tubercular osteomyelitis involving the bones of the fingers of both hands. The disease had existed for five years. Under local applications of ichthyol the swelling had gone down very much.

DR. SHERWELL said he would be inclined to try the syrup of the iodid of iron in order to eliminate all suspicion of hereditary syphilis.

DR. ROBINSON advised surgical interference, laying the fingers open, scraping them, and if necessary, amputating.

A Papular, Persistent Dermoneuritis.¹—Paper read by DR. JAMES C. JOHNSTON.

DR. LUSTGARTEN said he did not remember having seen the case reported in Dr. Johnston's paper. He objected to the name proposed by the author of the paper, because it implied an etiological connection. The neurotic symptoms, upon which Dr. Johnston laid so much stress, were probably of secondary origin. They certainly could not be accounted for from the appearance of the specimens which had been submitted to him for microscopic examination. The most prominent pathological feature was a necrobiosis, which was the result of an inflammatory condition, and if there was a neuritis it was probably secondary in its nature, as the neuritis in anesthetic leprosy has been demonstrated to be secondary and an ascending one.

DR. ELLIOT said that a careful examination of the specimens sent to him by Dr. Johnston had led him to the opinion that the case was one of sarcoma. There was a proliferation of the cells of connective tissue, and there were a number of cells which, to him, were indistinguishable from those of sarcoma. There were also a number of young, embryonic connective-tissue cells distributed in groups throughout the tissue.

Dr. Elliot said he did not think Dr. Johnston had proven a connection between the nerves and the conditions met with in the case reported. The nerve, surrounded by an infiltration, is met with in a number of processes. Then, again, he did not see why so much stress had been placed upon the formation of vesicles. Vesicles may be met with in any number of processes, while not forming a part of the symptoms. He would mention, as an example, pityriasis rubra pilaris, in which Van Giesen had described their occurrence and he had met with them frequently in his own sections.

DR. TAYLOR complimented Dr. Johnston on his paper, which showed close observation and careful pathological work.

DR. ROBINSON said the specimens which were sent to him for examination did not prove any connection with the nerve filaments. He did not think that the conditions described necessarily depended on a nerve lesion. As regards the vesicle formation, he agreed entirely with Dr. Elliot, and failed to understand why Dr. Welch had

¹ Will be published.

placed so much importance upon it. Vesicle formation was often observed in widely different skin diseases, and even in lichen planus, we may get a small, hard lesion with a minute vesicle. Consequently, he would not attach much weight to that feature of the case, nor upon the infiltration along the nerves, as we often get a round-cell collection along them, as well as along the blood-vessels. The speaker said that from his examination of the specimens submitted to him, he did not think of sarcoma; it impressed him as an inflammatory condition, with cell destruction of one part and inflammatory changes in another, with connective-tissue increase and cell infiltration along certain lines, such as we see very frequently. He did not think it had been proven that the conditions met with were of neurotic origin, although such might be the case.

DR. FORDYCE said he did not think Dr. Johnston intended to state positively that the inflammation of the nerve was the cause of the lesions. The case was certainly unique in its clinical features, but the histological appearance of the lesions was much the same as that seen in other chronic inflammations of the skin. There was nothing in the histological findings to explain the peculiar clinical course of the disease. The speaker said he did not think that the presence of young connective-tissue cells, which were referred to by Dr. Elliot, would point conclusively to sarcoma, because they are met with in so many inflammatory conditions.

DR. JOHNSTON, in closing the discussion, said he did not wish to imply in his paper that there was any etiological relationship between the neuritis and the dermititis; it is a coexistence merely. At the same time, inflammation of the nerve trunks was present in this case and was exactly similar to that seen in other forms of neuritis, for instance, in that due to alcohol or arsenic. Since the cell infiltration consisted chiefly in leucocytes, he thought the disease could hardly be called sarcomatous.

A Case of Favus.—DR. LUSTGARTEN showed a photograph of a case of favus of the body, which he had received from Dr. Schamberg of Philadelphia. This patient, Dr. Lustgarten said, had been first presented by him to the Society, January, 1895, with attacks of the same disease, and later by Dr. Fox. Dr. Schamberg writes that the man had another relapse, for which he is now under treatment at the Pennsylvania University Hospital. As in the previous attacks, the scalp has resisted invasion, the lesions being entirely confined to the body. Dr. Lustgarten said it would be interesting to study this case etilogically, because the clinical developments were out of the usual course. Favus of the body is usually very easily cured and does not necessarily relapse, while on the other hand the scalp, generally the starting point, will hardly ever escape in the long run. He, therefore, thinks it possible that the lesions in this case were due to the presence of a germ different from the one usually met with.

THE NEW YORK ACADEMY OF MEDICINE.

SECTION ON GENITO-URINARY SURGERY.

STATED MEETING, TUESDAY EVENING, APRIL 13, 1897, AT 8.15 O'CLOCK.

RAMON GUITERAS, M.D., *Chairman*.

Cancer of Testicle Involving the Omentum.—DR. EUGENE FULLER presented the specimen.

The patient was an Italian, forty-five years of age, first seen at the City Hospital. A bluish tumefaction presented at side of scrotum which looked like an hematocele. At the lower portion appeared a slough which he first thought to be the result of former operative interference. There was much extravasation, leading to the belief that it might be of traumatic origin. The house surgeon was instructed to cut through it carefully, layer after layer; he found a cellular mass. The growth extended through the inguinal canal following the structure of the cord and was adherent to the omentum. The latter was tied off and the inguinal glands removed. The hand was then introduced into the abdominal cavity where everything appeared to be normal. The speaker had never seen a cancer of the testicle which had extended up the inguinal canal and attached itself to the omentum.

The pathological examination showed it to be of a cancerous nature.

Discussion.—DR. TAYLOR opened the discussion by asking more of the details in regard to its histological structure.

DR. ALEXANDER asked whether the omentum was adherent to the cord, or whether it was an omental hernia which had become attached to the cord. The reason for his query was that a portion of the tumor had a constriction which looked as though it had been attached to the cord.

DR. FULLER closed the discussion by entering more into detail in regard to the structure. The growth was nodular and much infiltrated; the glands were much involved.

Catheterism of the Ureters with the Help of the Ureter Cystoscope. **Report of Seven Cases.**—By WILLY MEYER, M.D.

To speak at this date of the immense value, or of the necessity of performing cystoscopy and catheterism of the ureters in trying to clear up an obscure urinary disease, is rather a superfluous undertaking. Since Kelly's method of viewing the bladder and draining the kidneys in the female has come into general use; since special cystoscopic instruments, imported from the other side, are not needed to carry out this work, this method of cystoscopy now seems to be resorted to by operators everywhere when treating female patients. If the same method of ballooning the bladder with air and inspecting its interior through straight tubes introduced through the dilated urethra could be utilized in the male, the whole matter would be very simple. This can never be done on account of the anatomical fea-

tures of the male urethra; its limits to dilation, the fact of its being surrounded by the prostate gland in its posterior part, will forever exclude Kelly's method from being used in the male, and it can never compete with Nitze's method. We are justified in the assumption and can state the dictum: Cystoscopy and catheterism of the uterers in the male will forever be best carried out with instruments, the principles of which have been laid down by Nitze.

The ureters of the male can be catheterized and the kidneys drained without a previous cutting operation. The method will fail whenever the three cardinal conditions which make cystoscopy possible cannot be fulfilled, *viz.*:

1. The caliber of the urethra must be sufficiently large to allow the passage of the instrument.
2. The bladder must have a capacity of at least four to five ounces.
3. The fluid within the bladder must be made and kept transparent.

Sometimes the method is not successful owing to the fact that the mouths of the uterers cannot be found, or that they cannot be approached, or they are too small to allow an entrance to even the finest of catheters.

Dr. Meyer emphasized the fact that he catheterizes the ureters according to strict indications only, and never for the sake of personal practical experience. He does catheterism in the male only where a renal lesion has to be localized, where health or disease of its mate has to be determined, and where an operation on the kidney seems urgent, and would probably have to be done sooner or later.

In reference to the manipulation Dr. Meyers considers that to approach the ureteral mouth and to engage the tip of the tiny catheter in the same is not more difficult in the male than in the female. In order to be successful in the use of Casper's instruments one will do well to be guided by the following rules, the observance of which has yielded him invariable success:

1. Wash and cocainize the bladder according to well-known rules.
2. Fill the bladder with from five to seven ounces of clear fluid.
3. Introduce the instrument. For this purpose the ureter catheter should be pushed down to the internal opening of the canal of the cystoscope; the lid of the latter should be pulled out about one-third inch.
4. As soon as the beak has entered the bladder the catheter should be gently pushed forward into the vesical cavity by about $\frac{1}{2}$ to $\frac{3}{4}$ inch, and then the lid should be at once pushed into place, *i. e.*, it should be fully closed.
5. After the interior of the bladder has been satisfactorily inspected and the ureteral openings have come into view, approach one of them.
6. Let the ureteral opening appear at the very end of the cystoscopic picture, farthest from the middle of the bladder, but keep

it under your direct inspection, with the prism as near to it as possible.

7. Push the catheter gently forward; if the beak's direction is a proper one, *i. e.*, if it is parallel with that of the lower end of the ureter, the author was sure the ureteral catheter would almost invariably easily enter the mouth, when conducted by a trained hand.

8. Allow the catheter to proceed not more than one to two inches into the ureter, and withdraw the wire mandrel. Then, as a rule, urine will begin to flow, drop by drop, at intervals or continuously.

Thus far Dr. Meyers has met with but one case where he has been able to see and approach the ureteral opening without succeeding in introducing the catheter into the same. In this patient, Kelly's method failed in repeated sittings, as there was no catheter small enough—metal or flexible—to enter the mouth. The reason for this as ascertained with the cystoscope was that the ureter emerged, not as is usually the case, at the innermost end of the ureteral (intravesical) fold nearest the trigonum, but about one cm. above it. The mouth of the ureter was evidently congenitally constricted. However, chance determined the health of the opposite kidney. At a third sitting, in washing out the bladder the water returned clear from the beginning, and it seemed evident that the ureter of the diseased side was temporarily obstructed. On viewing the bladder after Kelly's method it was observed that the ureter of the presumably diseased side did not discharge a drop, while the other discharged profusely, and the urine of the latter proved to be perfectly normal. Dr. Weir successfully removed the diseased kidney. The operation as well as the specimen proved to be of unusual interest. (Conf. Report of the New York Surgical Society, March 10th, *Annals of Surgery*, 1897.)

Whether it is advisable for the patient to take a large amount of fluid before examination is still a mooted question. In the male Dr. Meyer considers it a wise plan. We must drain one kidney after the other, if possible in the same sitting. We cannot generally leave the catheter first introduced into one ureter in place; liberate it; catheterize the opposite side, leaving the catheter there also in situ, and remove the cystoscope, as there will be few urethræ found in the male of sufficiently large caliber. It may often be possible under general narcosis, but this for obvious reasons should be avoided as much as possible in this procedure. Ether as well as chloroform is detrimental to the renal tissue. In the male we are limited as to time, and the more fluid the patient has taken before examination, the more rapidly his kidneys will work. Due weight must be given this point in drawing conclusions from the urinary analysis.

In the female both kidneys may be drained for hours, provided we do the work at the patient's house or at the hospital. The urine can be separately collected, and analysis will be more satisfactory without diluting the renal secretion too much by previously ingested fluids.

As to finding out the amount of work done by the kidneys in a given time, Dr. Meyer formerly counted the drops that were dis-

charged through the ureter in so many seconds, and also counted the intervals between the discharges, but as the urine often drains alongside the catheter besides passing through its lumen, this seems unreliable. The catheters which accompany Nitze's ureter cystoscope are of more use in this respect than those of Casper's instrument. The former have an end-hole behind a scoop-shaped lengthening of the material of which the catheter is made, the whole forming a sort of bougie. In the female it is a matter of taste whether we use a cystoscope constructed on the Nitze plan or Kelly's instrument. The manipulation with the imported ureter cystoscope is certainly a very gentle one. A trained cystoscopist should be master of all methods that have proved useful and can be made use of for this purpose.

As to the indication for catheterism of the ureters it is our duty to try to collect separately and analyze the secretion of each kidney in the so-called obscure urinary diseases, provided the bladder-urine points to a renal lesion. It is a solemn duty to establish the presence, the health or disease, if possible, the working power of the opposite kidney if nephrectomy has to be done.

If physicians will come to appreciate the importance of this now feasible examination, and have cystoscopy and catheterism of the ureters in the male and female added to the other means at their disposal for arriving at a definite diagnosis, the so-called obscure urinary diseases will become a thing of the past, and diagnosis, instead of being merely guess work, will be put upon a scientific basis.

Discussion.—DR. ALEXANDER did not feel capable of adding anything which had not been touched upon by the speaker. He wished to thank Dr. Meyer for his contributions on the subject of cystoscopy and especially for this paper. He thought, however, one would get a false idea in regard to the ease of manipulation from it. He had not been as successful as Dr. Meyer, and could not account for the fact.

DR. OTIS was much indebted to Dr. Meyer for his paper. He thought the straight cystoscope with the opening behind was better, but he had not succeeded in getting an instrument which suited him. He presented to the section the instrument that he used. One can employ a perfectly straight catheter and the instrument can be used in any direction. One, too, can employ a metal catheter which permits of its being heated before its introduction. The instrument so far is a failure on account of establishing electric connections. He had great difficulty in having an instrument made which fulfilled the necessary requirements.

DR. FREDERIC E. SONDERN.—Through the kindness of Dr. Willy Meyer, I have had for examination the specimens of urine obtained from the cases he has mentioned.

The difficulties presented by an examination of bladder-urine, in endeavoring to make a diagnosis of the surgical diseases of the kidney, are manifold, and to infer the presence of a healthy kidney in addition to the diseased one is generally not possible without error, even in the most typical cases.

Surgical diseases of the kidney being so frequently associated

with primary or secondary affections of the bladder, the resulting bladder elements in the urine tend to hide the structures desired for diagnosis of the renal lesion. The large quantities of bladder pus, mucus, and group of epithelial cells thus make it more difficult to find a few casts, tubular plugs of pus originating in the kidney, elements of pseudoplasm, pathogenic organisms such as tubercle bacilli, gonococci, etc., and to differentiate groups of pelvic and other renal epithelial cells, to say nothing of the fermentation frequently begun in the bladder, which, if marked, as so frequently is the case, is apt to change the renal elements so that they cannot be recognized at all. The latter difficulty has been somewhat reduced by the use of the centrifugal apparatus as I described in the *Medical Journal* of February 25, 1893, by means of which a specimen can be examined immediately after it is passed and before the fermentation has been allowed to proceed.

The separate analysis of urine from each kidney, in connection with the clinical data, makes such a complete and positive diagnosis absolutely unequaled by any procedure which has hitherto been at our service, and justifies a conclusion as to the functional activity of each organ, which before has never been possible in the male. Such separate examination always decides if the pathological process is unilateral or bilateral, and with a record of the excretory power of each kidney in addition, we have the cardinal points in forming the indications or counterindications to surgical procedure.

For the sake of both operator and patient it is essential to minimize the time of collection, and therefore to employ methods of analysis requiring the smallest amounts of urine which will at the same time be consistent with thorough work. While I have found that six cubic centimeters form the smallest practicable amount required, it is, however, possible to use even less by carefully diluting the amount at hand, as would be indicated if for some reason a larger amount could not be obtained; and if ten cubic centimeters can be secured the work is even more easily done.

For the purpose of collection I use two glass tubes with stoppers ground in, marked respectively "right" and "left." These, after thorough cleansing, are sterilized in the usual manner and placed in a small box for safe transportation. On the back of the latter is a label calling for information as to the time required to collect the contained quantity from each kidney, and such other remarks as may be of value. Granted that we have six cubic centimeters in one of the sterile tubes, or as before stated if the amount is smaller, that an accurate dilution has been made, my method of procedure is as follows: This entire amount is poured into the receptacle of a Westphal's specific-gravity balance; and I may state that the apparatus is a very accurate one, far more so than the better class of urinometers. It is not possible to obtain one of the latter that will work with anywhere near such small quantities of fluid as we are considering here.

After noting the gravity indicated by the balance with the use of a series of weights, the sediment of the whole quantity is obtained by means of a centrifugal device, for which purpose one of the many

forms of apparatus now on the market may be used. I believe the best results follow a speed not excessive and continued for a longer period than otherwise. The sediment thus obtained is sufficient not only for the routine microscopic examination, but after this has been made the same deposit can be used for staining for pathogenic organisms, or such other purposes as the case in question may indicate (chemical tests to corroborate diagnosis of crystalline or amorphous deposits, etc.).

The remaining specimen is then carefully poured through a small filter, and after the reaction has been determined at least five cubic centimeters remain. Of this quantity one cubic centimeter is used for Heller's cold nitric-acid test for albumin, or Tanret's or the ferrocyanid of potash test, as the analyzer may prefer; one cubic centimeter for Esbach's picric-acid test to corroborate one or other of the former. If albumin has been found, the remaining three cubic centimeters are then boiled and the former filtered off.

One cubic centimeter is then used for the relative determination of urea, which I think is a most important point. Half a cubic centimeter, properly diluted, serves for the sugar test, for which at present I prefer the Whitney reagent, principally on account of the small amount of urine required and the fact that a quantitative result is obtained at the same time. Deducting shrinkage, one cubic centimeter now remains, which can be used for the approximate estimation of the chlorids present, or for one or other chemical test which the condition in question may indicate. After the specimen from each kidney has been thus manipulated and the results have been noted, it is an easy matter to draw logical conclusions as to the condition of each organ.

Bacteriological researches by means of cultures made from the specimens collected in the sterile tubes in the aseptic manner in which surgeons are in the habit of working, may be of much value in determining the etiological factors of the pathological conditions in question.

To recapitulate, the points on which information is desired, are the following:

Do the specimens from each kidney differ from one another in the following, and to what extent?

1. Quantity. Is there a unilateral polyuria, anuria, or diminished excretion in quantity?

2. Color.

3. Odor. As would be the case if there were a fermentation in the renal pelvis.

4. Reaction.

5. Specific gravity.

6. Deposit.

7. Quantity of urea and chlorids excreted in a given time—being the means of determining the comparative excretory power of each kidney.

8. Presence or absence of albumin and sugar.

9. Microscopic examination.

a. Evidences of the affection of the parenchyma to be considered in connection with the amount of albumin and the relative excretion of urea and chlorids.

b. Evidences of the condition of the renal pelvis, pyelitis, simple catarrh, etc.

c. Evidences of a pyonephrosis.

d. Etiological factors, elements of pseudoplasm, pathogenic organisms, evidences of stone.

DR. FULLER did not find it any easy matter to find and enter the ureter. He liked Dr. Otis's idea of straight cystoscope with opening behind. One should bear in mind the fact that there is more or less traumatism produced in introducing the instrument which might result in the production of sympathetic anuria; and if one ureter was blocked with a stone then we would have absolute anuria. He wished to caution the section against the production of sympathetic anuria.

DR. VALENTINE envied the speaker his success in cystoscopy which he thought to be due to his greater skill. He had failed with Casper's instrument, but had succeeded with Nitze's. The latter compared favorably with the former in that it is smaller and can the more readily be diverted to the right or left.

DR. MEYER closed the discussion. He thought some failures could be attributed to the presence of strictures. He thought Casper's and Nitze's both good instruments. The speaker again referred to his method of performing this difficult operation. In regard to traumatism, he had found but a very few blood-cells and never any hemorrhage. He always used a new catheter and never the same one twice. It was very difficult to boil a catheter for any length of time because it roughened the smooth surface. In tuberculous cases the operation must be done with the greatest care.

*Discussion on Dr. Alexander's Case of Endothelioma of the Penis.*¹

—DR. JOHNSTON, after a more thorough examination, reiterated his previous assertion that the growth is an endothelioma originating in the cavernous spaces. The tumor consists of a meshwork of fibrous and involuntary muscular tissue (trabeculæ of the corpora cavernosa) enclosing alveoli filled with cells. These latter are of two kinds, a smaller, oval or polyhedral cell with a vesicular nucleus, and an enormous cell with a large deeply staining nucleus. The connection of both with the lining endothelium can be readily traced. The lining is intact in places showing flattened cells; in others it is wanting, and the tumor elements seem ready to invade the surrounding tissue. Further, the growth has involved the endothelium of some of the venous channels entering the spaces. Chief interest attaches to the cells. Their nuclei show beautiful mitotic figures demonstrating the activity and probable malignancy of the growth. The large cells have been demonstrated by Cornil to be the exclusive product of endothelial proliferation, springing from the flattened cells either in inflammation or degenerative processes (*La Presse Méd.*, No. 24, 1897). They may be transformed into fibrous tissue (pleuritic ad-

¹ See page 247.

hesions), or as in the present case, undergo a hyalin degeneration. They exhibit a homogeneous protoplasm, large, deeply staining, single, polymorphous nuclei when recent. Later, degeneration of their substance takes place, the nuclei fragment and vacuoles appear. Leucocytes may and often do wander into the last, giving them the appearance of new-formed vessels. He has not seen the cell-nests described by Dr. Dunham. In this instance, at least, "fibroid sclerosis" is a decided misnomer.

DR. TAYLOR presented the following report on the specimen submitted to Dr. James Ewing:

Dr. Taylor's specimen from the corpus cavernosum is a carcinoma. These new cells in large alveoli cannot be of inflammatory origin, but present all the characteristics of tumor cells, *viz.*, great variations in size, mitotic figures, new connective tissue in the usual condition of mild inflammation commonly seen in cancer. There appears further to be a slight capsule developed about a part of the tumor in this section. The shape of the cells, very large and flat, makes it seem probable that they originated from squamous epithelium (epithelioma), but this I cannot say positively.

Selections.

CUTANEOUS DISEASES.

Fatty Seborrhea and Alopecia Areata. R. SABOURAUD (*Annals de l'Institut Pasteur*, February 25, 1897, p. 134).

In the hairy regions seborrhea has two symptoms, an overproduction of normal sebum and a dilatation of the sebaceous openings. To these must be added a paroxysmal loss of hair like the exudation itself, which in time becomes permanent. Numerous secondary affections attach themselves to it, such as pityriasis capitis and acne. The oily secretion, washed in ether and stained by the Gram method, shows numbers of a short bacillus which may attain the size of a μ and which stains easily. It is always found in the upper part of the hair follicle between its opening and that of its sebaceous apparatus. A cocoon of horny and fatty matter occurs in this situation which contains the bacillary colony in a pure state. The cocoon may degenerate, increase in size and constitute a comedo which shows the seborrheic bacillus at the center, and at the periphery a secondary infection. This determines the lesions of acne. The author found a white coccus, distinct from the staphylococcus in all forms of acne except the furuncular, which is due to the yellow variety. The secondary infections of seborrhea of the scalp have special, multiple parasites, the white coccus in particular.

The seborrheic cocoon, developing at the follicular orifice, kills the hair by interfering with the function of the papilla. There results a defluvium which progresses slowly or by acute attacks. The mechanism is comparable to that in alopecia areata. Sabouraud vigorously attacks the manner in which these facts have hitherto been

classified by Unna and his pupils. The bacillus can be cultivated on acid media (glycerin-peptone), the colonies being pointed, white in color when the medium contains no glycerin, otherwise, rose. The microbe is resistant and pure cultures can be made in a month, by a special method in a shorter time. Inoculations for several reasons did not offer complete proofs, so the author is driven to say that, while the microbe is the constant expression of seborrhea, he has not been able to demonstrate that it is the cause of the lesions.

This bacillus is the same found in alopecia areata. In this affection the hair dies following papillary atrophy, and so long as it persists the hair is not reformed. This mechanism is analogous to that of seborrheic alopecia. The bacillus is found only in diseased areas, the cocoons are the same, and the cultures identical. How can the difference be explained, and is the contagion of alopecia necessary, or may the disease be autogenic? No answer is forthcoming as yet. For the moment, it may be said that alopecia areata is an acute form of oily seborrhea. The remedies which are found best in seborrhea, such as sulphur, are indicated in alopecia areata. The author has succeeded in producing characteristic areas on the calf, rabbit, and guinea-pig, with pure cultures. It remains to be discovered by what mechanism each affection arises, and why they differ.

Common Alopecia. Its Nature, Cause, and Mechanism. R.

SABOURAUD (*Annals de Derm. et de Syph.*, t. viii, No. 3, 1897).

The study of ringworm led the author to that of alopecia areata; the latter to seborrhea, and seborrhea to alopecia. He summarizes his conclusions in the following words:

I. The specific microbacillus of oily seborrhea introduced into the pilo-sebaceous follicle causes there four constant results:

- (a) Sebaceous hypersecretion.
- (b) Hypertrophy of the sebaceous glands.
- (c) Progressive papillary atrophy.
- (d) The death of the hair.

a and *d* are functional phenomena, *b* and *c*, anatomical. These phenomena result from seborrheic infection as well on lanugo regions (the breast) as on other parts.

II. On the scalp, this infection has the vertex for its elective site, oily seborrhea giving rise to the baldness. *Common alopecia is only oily seborrhea of the vertex in a chronic state.*

Not only is the follicular seborrheic infection indispensable to the appearance of baldness, but that infection remains intense, pure and permanent until the alopecia is fully and definitely constituted; until the ultimate sclerosis of the follicles occurs.

III. Common alopecia is then a microbic, specific, perfectly characterized disease.

Quite the most remarkable statement in the paper relates to the action of the seborrheic toxin on the hair papilla. The cocoon (described in the preceding abstract) remains circumscribed in the upper third of the hair follicle; consequently, the bacilli themselves do not reach the papilla. Its death must then be produced by toxins gen-

erated in the neighborhood of the cocoon. Cultures of the microbe on artificial media furnished a toxin which, when injected into sheep, rabbits, and guinea-pigs, produced loss of hair without any other symptom. These inoculations, done under all conditions, seem to preclude every chance of error in the results obtained. Sabouraud also points out the errors of observation as to these facts, which have lead Unna and his pupils astray. They are three: (1) Examination of seborrhea by surface-scraping instead of section through the integument. (2) The misconception that the pathology and physiology of the follicle is the same as that of the epidermis, than which nothing is more false. (3) The presence of pityriasis accompanying alopecia. When the two occur coincidentally, the baldness is due to a subjacent seborrheic infection. The two may be mixed in any proportion.

The Local Treatment of the Regional Forms of Eczema. DR.

LOUIS A. DUHRING (*Amer. Journ. of Med. Sciences*, April, 1897).

The author says that while the two distinct modes of therapeutics, internal and external, are of great value, it is quite possible to cure the disease by applications alone. According to its minute anatomy, different regions of the skin call for varied remedies and methods of application. The variety of eczema and the stage of the process have important bearing. Certain regions exhibit a predilection for more or less constant clinical types, the face, in adults for example, for the erythematous form.

Eczema of the Scalp.—Eczema is usually scaly (pustular and crusted, in children) here, chronic and stimulating remedies are usually demanded. In pustular disease, crusts are to be removed with a bland oil, followed by soap and water and a mild salicylic acid salve. Ichthyol and a weak sulphur ointment are sometimes useful. Soaps are not usually efficacious. In adults, the disease occurs in scaly spots which itch and are consequently excoriated. Tar, in the form of the tincture, is useful, but must not be too strong, 15 to 20 minims to the ounce of water is sufficient. Pix liquida in ointment may be used instead, or ol. rusci in olive-oil. Calomel and white precipitate (20-80 grs. to $\frac{5}{8}$ i) are recommended. Obstinate cases of moist eczema are benefited by applications of a 1 to 5-per-cent. silver nitrate solution, followed by a soothing salve. Begin with weak preparations so as not to aggravate the disease.

Eczema of the Face.—Erythemato-vesicular, erythematous, subacute, acute, or chronic are the forms oftenest seen. Boric-acid lotion acts well. On the forehead, when the skin is thickened, camphor may be used in this form: camphor 3 ss, emplastr. plumbi 3 iii, petrolati 3 iii, ol. olivæ 3 i. A mucilage of tragacanth gives a cooling sensation. Lotions are especially indicated, zinc oxid with lead-water, zinc oxid and lime water, boric acid. Lassar's paste with salicylic, resorcin, or carbolic is invaluable. The last should not be used on hairy parts.

Eczema of the Lips.—Disease here is very rebellious. It may be quite acute but is usually scaly and fissured. Depending on the stage,

lotions or strong stimulants (silver) may be applied, while hygiene is not to be neglected.

Eczema of the Lids.—Blepharitis is usually eczematous. Aside from general measures, local asepsis is insisted on (bichlorid solution, 1-10,000, or silver). A good ointment consists of lanolin, 3 iii, ol. amygdal. dulc. and water, each 3 ss.

Eczema of the Beard.—Lotions, pastes, plasters and ointments, especially those containing mercury and sulphur in small quantity, are useful. Salicylic plasters (2 to 5 per cent.) should be worn day and night, when practicable, the face shaved every other day.

Eczema of the Ears.—Local treatment is difficult. Salves are more serviceable than lotions, *e. g.*, Lassar's paste with salicylic acid, tar, or calomel. Fissures should be touched with silver nitrate.

Eczema of the Trunk, Thighs, and Arms.—The eruption is apt to be symmetrical, diffuse, and in the form of erythema, papules, or vesico-papules. The back, hip, and thigh, are favorite seats. In acute stages, the lotions and powders are to be used; later, when scaling, the pastes. Beneath the breasts, in the groins and axillæ, a tannic acid or weak sulphur paste is serviceable.

Eczema of the Genitals.—The scrotum and labia are chiefly attacked, and the disease is most refractory. Pruritus and glycosuria must be excluded. Strong applications (tar ointment, $\frac{3}{4}$ i, calomel, 3 i, carbolic acid, gr. xv) are indicated in chronic scrotal disease. Tincture of tar, Vleminckx's solution, potassa, etc., are better tolerated than harsh measures elsewhere. They should be followed by a soothing paste or powder. On the genitals, eczema is often neurotic, and demands suitable general treatment.

Eczema of the Anus.—The diagnosis from pruritus is of importance. Inspection must be insisted on, piles, excoriations, and fissures treated. Hot water applications, followed by lotion or ointment, gives good results often in cases which have resisted heroic remedies. This formula is recommended: sulphur, gr. xl, naphthol, gr. xx, morphin, gr. ii, zinc carbonate, 3 i, cold cream, $\frac{3}{4}$ i. Care must be taken in selection of a base, as certain ones act well where others do not. Almost all cases are curable by a combination of internal, general, and local treatment.

Eczema of the Nipples.—Usually only one is attacked and the disease circumscribed about it. Vigorous treatment is well tolerated, and may as well be employed first as last. Possibility of Paget's disease should be borne constantly in mind. If the latter is vigorously attacked in the beginning, an operation may be saved.

Eczema of the Leg.—The acute forms have here a tendency to pass into deep-seated eczema rubrum or madidans. The stage depends on age and condition of the subject, venous stasis, scratching, and local infection. Black wash acts well in the weeping stage. Plasters are an improvement over inunction whether the patch is wet or dry. Unna's plaster-mulls are useful but difficult to obtain. This formula can be made up anywhere: Liquefied soap plaster (U. S. P.), 90 parts, olive oil, 10 parts. As a base, it may be combined with a variety of drugs. The stiffer the plaster the less frequently need it

be changed. When salicylic acid is used, less olive oil is put in, as the former's action is softening. Soft soap and water, followed by diachylon ointment are referred to, in connection with *ecz. rubrum*. Potassa will remove verrucous thickening. The rubber bandage frequently aggravates the disease. The glycerin-gelatin preparations are of particular service in dispensary practice. Ichthyol especially combines well with them.

Eczema of the Hands.—The feet and toes are less commonly attacked than the hands. A multifiform eruption is quite usual and fissuring apt to occur. The subjects are often neurotic as they are in cheiropompholyx. Calomel salve may be gently rubbed in three times a day. Tar and diachylon are serviceable. On small patches, tar with comp. tinct. of benzoin or collodion may be applied as a continuous dressing. Rubber gloves are not viewed with favor.

Eczema of the Palms and Soles.—The process is almost always chronic, the skin being fissured, thick and scaly. Both hands or both feet are simultaneously involved, rarely all four surfaces. Their obstinate rebellion to treatment is proverbial. Tar and carbolic are not well tolerated. Mercury, ichthyol, resorcin, and sulphur, act better. Epidermic thickening should be removed before treatment begins. The efficacy of salicylic plaster is well known and its emollient effect is of importance, particularly in the case of the soles. The same laws which make syphilis here obstinate to treatment, hold for eczema as well, and make the employment of general measures necessary.

Origin of Giant Cells.—ANTON BROSCHE (*Virchow's Archiv.*, 1896) concludes as follows:

1. Giant cells may not only originate from degenerated angioblasts, endothelia, white blood-corpuscles, etc., but also, in certain instances, from newly formed vessels of large caliber, as a result of a peculiar (perhaps tuberculous) affection of the vessel-wall and a coexistent, still unknown, regressive metamorphosis. The existence of large giant cells with double nuclear wreath may be taken as proof of the accuracy of this assumption.

2. It is also possible that obliteration of the vessel lumen by proliferation of diseased intima cells (endothelial cells), and the formation of ectases by such obliteration, or by compression and distortion from without (by cellular infiltration and nodule formation in the immediate neighborhood), may play an important rôle in favoring the generation of giant cells from newly formed vessels of large caliber.

3. Since connective tissue occurs everywhere in the organism, and, as Bizzozero and Bozzolo have shown, can assume an endothelioid character, it is not improbable that all giant cells are derivatives of endothelium, or of endothelioid connective-tissue cells.

Tuberculides.—DARIER (*Annals de Derm. et de Syph.*, No. 12, 1896).

This name is proposed to the Soc. Franc. de Derm. et de Syph. for the group of diseases comprising *acne cachecticorum*, *acne*

scrofulosorum, grouped folliculitis, acnitis, hydradenitis, etc. The author thinks a kinship exists between them and tuberculosis since they occur with the pulmonary and often with some other cutaneous form. The nature of the relation does not, however, appear, for bacilli have never been found in the lesions, and our knowledge of toxins and their etiological rôle in dermatitis is too little known to warrant even a conjecture. He presented two cases, one of Barthélemy's acnitis, the other of acne cachecticorum.

Seborrheic Eczemas or the Seborrheites. L. BROcq (*La Presse Médicale*, No. 19, 1897, p. 101).

Three cases, the circinate, weeping, and psoriasiform varieties, are described, and the author claims that they constitute a morbid group for which the term eczema is a decided misnomer. Audrey's appellation, dermatosis of Unna, is open to objection. Seborrheitis recommends itself to Brocq as being an easy way out of the difficulty. He would call the forms which occur on the scalp pityriasic seborrheitis, the circinate, seborrheitis circinata, seborrheitis psoriasiformis, etc. It is the same disease, its varieties due to differences in soil, and perhaps a plurality of microbes. (Etymologically, the term is an indefensible abomination, since reduced to plain English it signifies an inflammation of an over-secretion of oil.)

Clinical and Histological Study of Rhinophyma. DOHI (*Arch. f. Derm. u. Syph.*, Bd. xxxii, No. 3, p. 371).

Histological studies were made on two cases. The length and dilatation of the sebaceous excretory ducts were striking. They were lined to the border of the lobules by thick epidermis, showing the stratum granulosum. The lobules were voluminous, subdivided several times and lay, surrounding the duct, superficially so that the latter opened at the bottom of a depression or else were entirely sub-jacent to it. The epidermis was thin. The basal cells contained a yellow pigment. The dermic papillæ were slightly elongated. In these latter and around the glandular cul-de-sac the connective tissue showed no change; around the ducts there was some sclerosis. The vessels showed thickened endothelium with nuclear increase. In sections from the border of the tumors the author found evidence of chronic edema; the connective-tissue cells were hypertrophied, their protoplasm reticulated and vacuolated. The fibrillar bundles were separated and the lacunæ contained masses of granules. There was a varicose condition of the veins, and in places, narrow, almost rectilinear vessels, with thick walls. Unna's plasma cells occurred in masses about the vessels, which, when very considerable, reduced the fundamental tissue to a few fibers. Abscesses, seen about the glands were sterile, but various micro-organisms were found in the glandular contents. The author thinks that the primitive phenomenon is vascular dilatation, and that in sequence follow stasis, hyperemia, and trophic disturbances. To these lesions an inflammatory element should be added. In other words, rhinophyma is a rosacea complicated with an inflammatory acne.

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Original Communications.

THE RELATION OF OXALURIA AND URIC-ACID EXCESS TO GENITO-URINARY INFLAMMATIONS AND DISORDERS.

BY BRANSFORD LEWIS, M.D.,

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and to St. Mary's Infirmary, St. Louis.

I FELT some hesitation in introducing this subject before this Association. It seemed, at first thought, to be a sort of *ça-va-sans-dire* affair, which every one acknowledged and appeared, in a way, to believe in. And yet, so far as I was able to discover, that acknowledgment has been rather by inference; has been desultory; has lacked formulation and delineation. References to uric-acid urethritis, according to my memory, have been in the shape of simply mentioning the fact that such a thing is possible and does actually occur, and is not denied by the writer—and there the subject is dropped. It has been introduced only to be mentioned as one of the numerous causes of “simple” urethritis.

My clinical impressions—not those derived from the writings above referred to—have made me think that the inflammations and disorders arising from this source are not always as “simple” and easily disposed of, practically, as the subject is in the literature. While Haig¹ devotes the space of a book—and a valuable one it is—to the uric-acid diathesis, he has nothing to say about the

¹ “Uric Acid in Disease.”

effects of that diathesis on the urinary organs. Keyes¹ speaks of the causes of over-acidity of urine as being rheumatic diathesis, old age, use of wines, etc.; and says, "There are no inflammatory conditions, acute or chronic, of any portion of the urinary passages which are not distinctly aggravated by over-acid urine, while some of them are caused, in the first place, by it." He looks on the oxalate of lime crystals as rather an accompanying symptom than a causative factor in certain disease conditions in which they occur. Taylor² in referring to urethritis in young boys names as causes, ascribed up to date, among other things, calculi and urine containing an excess of uric acid. These, he says, may produce urethritis, but its course, like the analogous condition in the adult, will be sub-acute and its duration short. As an injurious agent, in this relation, it seems to be considered as an insignificant affair. White and Martin³ under the heading, "Irritative or Abortive Gonorrhea—Non-specific Urethritis" say: "This form of urethritis arises from contact with foul discharges, from traumatism, or from irritating conditions of the urine. . . . Its course is different [from that of gonorrhea]. Unless the inflammation is treated by irritants, the symptoms do not increase in severity. Neither ardor urinæ nor chordee develops. The discharge continues for five to ten days and then ceases spontaneously." (Page 99.) And on page 620, referring to alterations in the urine, it is said that "there is an obscure condition known as essential oxaluria, or the oxalic diathesis, in which the elimination of oxalic acid is markedly, though irregularly, increased." No evidence of its assuming any importance in urinary pathology, inflammations, hematuria, etc., is given, so far as I could find. While Sir Henry Thompson⁴ treats at length, in a most attractive manner, the various phases and effects of calculus formation, both oxalic and uric, he has not, so far as I have been able to discover, given us the effects of these two substances persistently carried in the urine and brought in contact thereby with the urinary channels. Roberts⁵ notes the excessive deposition of oxalate of lime crystals in connection with certain nervous or hypochondriacal states, but asserts that "at the most, oxaluria is only one in a long list of symptoms, and one of the least significant." Uric-acid excess is considered mostly from the standpoints of the general gouty con-

¹ "Genito-Urinary Diseases with Syphilis," 1888, page 322.

² "Venereal Diseases," 1895, page 163.

³ "Genito-Urinary Surgery and Venereal Diseases," 1897, page 99.

⁴ "Diseases of the Urinary Organs," 1888.

⁵ "Urinary and Renal Diseases," 1885.

dition, or of calculus formation. Gouley¹ in two pages devoted to the causation of urethritis (page 209), makes some exceedingly pertinent remarks on the subject engaging our attention. He speaks of gouty urethral discharges which in certain cases last many weeks; or occur in each succeeding attack of the gout—in which case the urine will be found to be loaded with uric-acid sand, producing ardor urina and other more or less severe or persistent symptoms and signs (hematuria, pus, etc.). And (page 106) speaks of the fact that some of the most distressing cases of cystitis are caused by uric-acid excess; that persistent oxaluria causes trachelo-cystitis. But that is practically the extent of his writings on the bearing of uric-acid excess and oxaluria on genito-urinary diseases.

Without going further into the details of my research for literature on this subject, except to say that it has embraced an examination of both current and text-book literature, English, French, and German, at my disposal, I may say that the result has not been at all satisfactory. No writers that I have found, have devoted the attention to the subject that it deserves.

In the discussion of this subject I believe it is not necessary to go into the pathological processes giving rise to oxaluria and excessive uric-acid elimination. It is, rather, a question of whether, if those conditions occur, in given cases, do they then cause effects that result in disease in the genito-urinary system; or, disease being already present in that system, do they add to it, or tend to perpetuate it, or have any bearing on it that should justly engage the attention of the genito-urinary surgeon, either in his practice or his writings?

In this paper I have ventured to bring to your attention what testimony I have to bear on that subject.

CASE I.—Chronic antero-posterior urethritis; prostatorrhea; oxaluria.

John H., æt. twenty-four, English, laborer. Strong, ruddy, healthy looking fellow.

In early youth he practised masturbation to a moderate extent. When about eighteen years of age he began to notice that ejaculation was very easily excited, occurring upon slight handling of women; or an oozing from the urethra of mucilaginous material would follow the passage of a hard stool. He thought to prevent this by regular sexual intercourse, but found that ineffectual; ejaculation was precipitate, pleasure nil, and the untimely oozing, together with immoderately frequent night-emissions, continued.

¹ "Diseases of the Urinary Apparatus," 1892.

The patient's general health, formerly sound and vigorous, began slowly to decline—notwithstanding his outdoor life and the active exercise obtained in his employment. He had never yet had gonorrhea or any venereal disease. The decline in health was indicated chiefly by marked exhaustion and a “tired feeling” that was present not only in the lazy months of spring, but was equally intense during the other parts of the year—especially accentuated, however, after several night-emissions occurring in close sequence.

Finally, in 1890, he acquired a gonorrhea, which lasted for six months, with discharge, and on subsiding, was followed again by the oozing of prostatic fluid and the constant feeling of exhaustion.

In February, 1892, the patient consulted me, giving the above history. Physical examination showed nothing markedly abnormal with his external genitals; some sensitiveness but no stricture of the urethra. Double-glass urine test gave cloudings in both portions, which on microscopical examination were shown to be pus in moderate abundance and calcium oxalate crystals in excessive quantities.

In order to learn if this were a transient or persistent condition, repeated specimens were obtained and examined before any treatment was given; and each time the enormous number of lime oxalate crystals showed in the urine. They were of the envelope-shape.

At first peptonated cod-liver oil and milk was given internally, and antero-posterior irrigations of zinc sulphate, locally, no other measures being taken to modify the oxalate excretion. This was kept up from February 24th to March 27th—about one month. Locally, there was considerable improvement; both parts of the urine cleared distinctly; but the tired feeling and intense exhaustion on working were not a particle lessened. There had been no diminution in the oxalates.

He was then directed to eat less of vegetables, more of meat, and was given lithiated hydrangea, 1 dram three times daily. My next history-note, of April 30, 1892, says that both local and general improvement had followed immediately on the adoption of the last-mentioned régime. The patient remarked, over and over again, on the fact that he could work as hard as his fellow-laborers without any excessive tiring; and the emissions had lessened definitely and satisfactorily.

A note of July, 1892, says that the improved condition continued until the patient, about that time, had intercourse with a woman who gave him a fresh gonorrhea. Though he had the local inflam-

mation thereafter, the systemic and other symptoms and signs connected with oxaluria did not reappear so long as he observed the measures for preventing the oxaluria.

CASE II.—Nocturnal emissions; excessive and debilitating oxaluria.

A case that was more rebellious to treatment, yet not less related to an excessive excretion of oxalate of lime, is the following:

R. P., æt. twenty-two, American, clerk. This patient before coming to me (September 21, 1894) had gone the rounds of the practitioners, both special and general. He had received all sorts of treatment apparently, internal and local; injections, sounds, cold douches, psychrophors, etc., but without any relief. He was well built, but, differing from the previous one, was markedly pale. He had never had any venereal disease, and had had intercourse only a very few times. At about his fifteenth year he masturbated once or twice weekly for a time, but discontinued the practice in less than a year. About one or two years later he began to note an increase in the frequency of nocturnal emissions; and to the increased frequency was gradually added a feeling of debility or apathy following each such emission, lasting sometimes for days. The patient was an intelligent individual, of firm purpose and ideas, and not at all liable to be influenced in this regard by hysterical notions. His sufferings were evidently real and not fancied. At the time of his consulting me he was having emissions, with the accompanying depression, two or three times a week.

In examining physically, I first noticed that the foreskin was long and phimosed. Next, a hypersensitiveness of the urethra, especially in the posterior portion, that I have seldom seen surpassed in intensity. And, thirdly, a large number of calcium oxalate crystals in the urine—which was otherwise clear and free from defects.

After recovery from the circumcision, which was clearly needed, I began the use of measures, both internal and local, that were calculated, first, to remove the irritating influence of the oxalate crystals, and second, to soothe the irritated mucous membrane of the urethra; in other words, internally, citrate of lithium tablets, with a large quantity of water; locally, sedative suppositories per rectum and dilute kathammon irrigations to the whole urethra.

Improvement did not follow immediately; different means for securing the objects mentioned were tried successively. The lithium seemed to have little effect; likewise lithiated hydrangea; and it was only after sodium salicylate was given in considerable doses

that there was a diminution, and then disappearance, of the oxalate crystals. And then there was coincident lessening in the frequency of emissions and the severity of their effects. The patient did improve then very steadily and satisfactorily. But after some months he took a trip out of the city, discontinued for a month the régime prescribed, and on his return was back in his former condition. From this he was again relieved, however, by following up the lines found beneficial.

CASE III.—Impotence; frequent emissions; oxaluria. Consultation, January 8, 1895.

D. T. McK. of Colorado, æt. twenty-eight, telegraph operator. Never had venereal disease; had only attempted copulation a few times, and never satisfactorily. About his eighteenth year he began to notice the occurrence of night-emissions about once a week, then once in four or five days, and they seemed to leave depressing effects on him.

His essays at intercourse had been with prostitutes and were almost invariably attended with failure—erections starting out bravely, but dwindling with the attempt at intromission. Indeed, the only pleasure he got in intercourse was in that of his dreams, in which there was voluptuous sensation with the accompanying emission.

Examination disclosed post-urethral irritation, and great numbers of oxalate of lime crystals present in each of several specimens examined.

He was treated on the plan already mentioned, and in a little over three weeks reported successful and pleasurable intercourse for three nights in succession. His oxaluria had in the meantime disappeared, sodium salicylate, together with the dietary instituted, having seemed to be largely instrumental in securing that result.

CASE IV.—Acute antero-posterior urethritis; oxaluria.

C. C. McM., American, æt. thirty-four, medical student, married nine years. Consultation, November 23, 1893. Never had venereal disease of any kind. Seven weeks before coming he had first noticed frequency and burning at urination; there was no discharge at any time. Symptoms would get better and then worse without apparent cause. November 18th the meatus was opened by a surgeon, who prescribed for him also, but without permanent effect. Examination showed intense sensitiveness and irritability of the urethra, both in the anterior and posterior portions. First part of the urine cloudy, the second shreddy; both loaded with oxalate of calcium crystals. Repeated examination showed the persistence of

this abnormality. This patient was advised as to his diet, was given lithiated hydrangea, and after five office calls was pronounced relieved—with a caution as to future conduct in diet.

CASE V.—Chronic antero-posterior urethritis; oxaluria.

Wm. C., American, æt. twenty-three, medical student. Consultation, January 16, 1894. This case was somewhat similar to the above, except that the patient was unmarried and had never had sexual intercourse.

For two years he had been having recurring attacks of frequency, pain, and burning connected with urination, the last attack beginning a month before. The most pronounced deviation from the normal was clouding of both parts of the urine, produced only by the enormous amount of calcium oxalate crystals which they contained. The condition was simply one of oxaluria with consequent antero-posterior urethral irritation, and was relieved by treatment based on that interpretation.

In this, as in other cases I have observed, the oxalate crystals were so numerous that they could easily be seen macroscopically as a diffused milkiness of the urine.

CASE VI.—Chronic subacute non-gonorrheal urethritis, antero-posterior; partial impotence; oxaluria.

Chas. McC., American, æt. twenty-seven, druggist, unmarried. Had never had gonorrhea or any venereal affection; had never masturbated excessively; had never practised too much “unrequited” dalliance with women; neither had he sexual intercourse more than once or twice a month. Was moderate in all his tastes and habits.

His complaint was, that though formerly his sexual faculty was beyond criticism, during the latter four or five years there had been a growing diminution in the strength and duration of erections, with precipitate ejaculations, so that he obtained little pleasure and no satisfaction from the act of copulation.

Both parts of the urine in this case were markedly cloudy; but on applying it to microscopical test the clouding was seen to be chiefly from oxalate crystals with a small admixture of pus.

The meatus was cut from 18 to 30 French. Citrate of lithium tablets were given for a time but they did not diminish the crystals; and then salicylate tablets were prescribed, after which they disappeared for a time but reappeared when the dietary was relaxed. Then tartar lithin tablets were given, ten daily, with renewed improvement. In the meantime the inflammatory indications had diminished in the urethra and erections were stronger. The result of this case was satisfactory.

CASE VII.—Chronic antero-posterior urethritis; premature emissions; oxaluria.

T. R. S., American, æt. twenty-seven, bookkeeper, male, unmarried. Came December 28, 1894. Had gonorrhea eight years before, from which he had apparently recovered. About four years ago he began to have frequent nocturnal emissions—three or four a week; and, later, sexual intercourse proved very unsatisfactory on account of the premature emissions that invariably occurred, with second, as well as first attempts. The patient had had various treatments from different physicians, but none had given relief from the above and other evidences of posterior urethral irritability that were present. Both urines were shreddy and contained an excess of oxalate of calcium crystals.

Antilithics, diet, and local irrigations brought about a good result in this case—proved so by the patient's marrying subsequently and having no further trouble in intercourse.

CASE VIII.—Chronic antero-posterior urethritis; uric-acid excess.

M. J. B., American, æt. fifty-five, widower, merchant. First had gonorrhea twenty-five years ago, before his marriage; recovery. Later, after the death of his wife, he had frequently noticed that after either drinking or having intercourse he would have irritation of the urethra, shown by burning in urination, and perhaps a little discharge. His urine would be highly colored at such times. For two weeks before consulting me (November 3, 1893) he had been having an attack of this kind—following immediately on an intercourse thought to be entirely "safe." Close examination of the discharge repeatedly failed to disclose gonococci. But, the urine, besides containing pus in both portions, was loaded with urates and uric acid, and was highly colored and dense.

At first local treatment chiefly was used but it produced but small effect and was shown to be of little service, used alone. Later on, to the irrigations with zinc sulphate was added the internal use of citrate of lithium tablets with copious water-drinking. The effect of this, together with the non-nitrogenous dietary established, was markedly gratifying. The irritation of uric acid having been withdrawn, the urethra improved steadily and healed entirely. Since then (1893) the only recurrences of urethral irritation have followed on indiscretions in diet or drinking; and the patient has learned to correct these with drinking freely of water and citrate tablets and observing a more exemplary diet.

CASE IX.—Posterior urethritis, acute; seminal vesiculitis (right); oxaluria; urinary infection; right ureteritis.

H. S. K., æt. forty, American, married ten years, baker. This case, which seemed to have puzzled the preceding physicians no little, gave a history approximately as follows: Gonorrheal urethritis twenty years before; recovery after about three months and no subsequent return.

Beginning with New Year's Day of 1896, the patient had, at two-weeks' interval, several attacks of markedly frequent urination with intense burning pain in the posterior urethra; also, a severe aching pain in the right lumbar region. He could think of no cause to account for the trouble; there had been no "promiscuous" intercourse.

At about the third of these attacks I was called in—finding him with fever, pain, and other symptoms mentioned. Urine scanty and very cloudy in both portions, containing much pus, cocci, and rod-bacteria, and great quantities of oxalate of lime crystals. The right seminal vesicle was much swollen and tender; and on milking a considerable quantity of sanguino-purulent semen was expressed. I interpreted the condition as one of urethral-oxalate irritation, followed by urinary infection (no gonococci, numerous searches for them) and acute vesiculitis. He was given sedative treatment—rest, morphin suppositories, hot rectal injections, and, internally, thirty grains of urotropin daily, with an exclusively meat diet. These measures produced a radical and prompt change, so that in seven days the symptoms had nearly disappeared and no oxalate crystals were to be found. After that there was steady recuperation for a month, when suddenly, on March 21st, there was a renewed attack of post-urethritis, pain, and frequent urination, etc.

Indicative of an extension upward of the infection, there was spontaneous pain, as well as tenderness on pressure in the course of the right ureter and extending downward toward the right testicle. Nausea and vomiting were prominent features. In addition to the pus there were blood-corpuscles in the urine in moderate number, and a quantity of mucus; amorphous urates but no oxalates; epithelia, both round and tailed; acid reaction. Acute ureteritis was added to the diagnosis, and both internal and local measures were given for its relief, with sedatives to tide him over the acuteness of the situation. The patient improved again and gradually recovered from his several complications. I looked for a right-sided pyelitis also, in this case, but could get no indications of it.

In a recent interview with this patient I learned that he had had

no recurrence of the attacks after adopting the line of diet suggested for him then; he has felt strong and well ever since (about fifteen months).

CASE X.—Uric-acid oliguria.

F. J. L., American, æt. thirty-five, manufacturer, unmarried. This patient had been a high liver in all respects since his adolescence; drinks much of alcoholic liquors, champagnes, etc. He claims that notwithstanding escapades in venery, he has never yet had gonorrhea.

On February 11, 1897, I was called by his regular physician to catheterize him, as there had been some difficulty in getting urine from him. The doctor said that for the last forty-eight hours the patient had passed very little urine—he seemed to be unable to expel it, for some reason, and that since the day before there had been only two or three ounces. On the morning of his call for me he had introduced a catheter, but was in doubt as to whether it had gotten into the bladder, as only about half an ounce of urine came away.

I readily passed a urethral catheter, meeting with no obstruction in the urethra or prostate, and obtained half an ounce of highly colored, dense urine, loaded with urates and uric acid. There was no inflammation of the urinary organs; no casts or albumen. It was a uric-acid crisis, in my opinion, with oliguria as a result. In this case, too, there was intense nausea on the slightest provocation, the passage of the catheter, even, awakening it.

The patient was given salophen, with as much water as he could dispose of, and hot affusions were suggested for application over his renal regions.

The result showed the correctness of the diagnosis; he was urinating all right the next day and was out as usual.

I learned that the patient had had somewhat similar attacks before, once in October, 1896, while in New York, at which time there seemed to have been a spasmodic retention of some sort, as on the introduction of a catheter a large quantity of urine had been drawn off.

CASE XI.—Posterior urethritis; uric-acid excess.

M. H., American, æt. forty, surgeon, married. Consulted me in February, 1897. He had had gonorrhea in former years, when a young man, but had recovered and noticed no evidences of its return in some fifteen years of married life, during which he had been continent.

Occasionally, in the last winter, he had noticed recurring attacks of frequency of urination, and much burning connected with the act.

He was compelled to get up at night to urinate—something he had never found necessary before.

He tried different local injections that he had found serviceable for inflamed urethras in his practice, and also complete irrigations with permanganate solutions—but all without the slightest benefit.

My examination disclosed no abnormality except an excess of uric acid and urates; and questioning developed the fact that he was a hearty meat-eater, favoring that more than a vegetable diet.

Discontinuing all further local treatment, I suggested his avoidance of the sweets and red meats, liquors, etc., and adopting a vegetable-and-milk diet; also, that he take about fifteen or twenty grains daily of sodium salicylate, and drink good water freely. A report received about three weeks later said that all trouble had subsided and that he considered himself well again.

CASE XII.—Posterior urethral irritation from uric-acid excess.

Wm. R., American, æt. thirty-six, salesman, male, married ten years. Consultation October 13, 1895. Patient had never had any venereal disease, and has been continent all his married life. First began to notice, in 1893, a frequent necessity to urinate. Never had discharge or indication of direct urethral inflammation save this and a slight amount of burning which he occasionally felt in urinating. He was, at the time of his first call, in the habit of urinating from five to seven times in the day and one or two in the night.

His meatus admitted only number 20 French sound. The urine was perfectly clear, acid, and contained no albumen, pus, or other abnormal ingredients. The small meatus was considered the most likely cause for the symptoms, in the absence of infection or other cause then apparent; and it was cut to receive number 30 French sound. After that, irrigations of vegetable astringent antiseptics, of permanganate of potash, deep silver-nitrate injections, and sounds were tried successively but with only partial success. A possible uric-acid feature had not at first been thought of. Later examinations of the urine showed the presence of a larger than normal proportion of amorphous urates, and sodium salicylate was given more tentatively than otherwise. It proved of marked assistance—together with the vegetable dietary established at the same time—and the patient's recovery was not long delayed after that. In conversation with him a year later I learned that he had had no recurrence of the trouble.

CASE XIII.—Uric-acid diathesis; grave hypochondria; posterior urethritis.

C. L. M., American, æt. forty-four, merchant, married eight

years. Date of first consultation October 21, 1895. No history of gonorrheal infection, though he had chancroid when a youth. He asserted that his present urethral affection had begun some ten months before, at which time he noticed the very intense coloration of the urine; it was so highly colored that he at first thought it was bloody. After that there was urethral irritation, shown at times by burning in urination, or in a peculiar hesitancy of the stream.

This patient was in a highly nervous state, was mentally agitated to such a degree that no lucid history could be obtained from him. His condition of hypochondria was apparently bordering on mania, and, indeed, as I predicted at the time would be the case unless something were done to control him, he ended in an asylum.

Examination, however, showed intense clouding of both parts of the urine with pus and amorphous urates, epithelia, blood-corpuscles, and micrococci. The meatus was almost a pin-head size, but was enlarged by me to admit number 28 French sound.

The burden of his complaint was with reference to what he called insomnia, though this was more imaginary than real; he slept sufficiently for all practical purposes.

He was so very erratic and excitable that I could do nothing for him and was glad to recommend him to the care of an alienist for attention to his mental malady—the most serious, by far, of the evidences of his disease.

What connection there was between this and his uric-acid tendency, I could not say; but there evidently was a close connection between the latter and his urethral inflammation. For a portion of the ten days he was with me I was able to get him to take some sodium salicylate, from which there was a distinct, though transient benefit—proportioned to the time he was under the influence of the drug.

The following case is one of the most interesting of this series that I have studied. And I believe that failure to appreciate the nature of his case—the oxaluria underlying it—resulted in not only the failure of two prominent surgeons to afford any relief, but also led to their doing actual damage to an already irritated and inflamed urinary channel.

CASE XIV.—Oxaluria and uric-acid excess; post-urethral, prostatic, and renal irritation; chronic seminal vesiculitis.

W. A. L., male American, æt. forty-one, office work. Consulted me November 12, 1895. Patient had gonorrhea twenty years ago, but thought he had recovered long since. In 1890 he began to notice, without apparent cause, an increased frequency of urination,

causing him to pass water about eight times in the day and from one to three times at night. There was also, at times, some burning and irritation connected with the act. And then he began to notice a bloodiness of the urine. He consulted one of the general surgeons of St. Louis who ventured no explanation of the point of origin of the blood, but treated him with sounds for a year and a half, with no benefit in regard to either frequency of urination or the hematuria. After that, while in New York, he called on a well-known surgeon there, who, after making an endoscopic examination of his urethra, made a rapid dilatation of the organ to a very large caliber. From that time the trouble was worse than ever.

In February, 1895, when he came to me, there was hematuria, frequency of urination with sensations in the perineal region that were incessantly annoying, while there were marked systemic symptoms of debilitated vitality—weakness and lack of energy, exhaustion after the smallest amount of exercise, etc. Urine small in amount, acid; 1026 sp. gr.; cloudy in both portions from admixture of pus, blood, calcium oxalate crystals, and an inordinate amount of amorphous urates. Very frequently there were spermatozoa in both parts of the urine, occurring without reference to venereal excitement, emissions, or action of the bowels, showing a relaxation of the vesicular and ejaculatory ducts. On settling, a large number of uric-acid crystals readily appeared in the bottom of the highly colored urine. While there were present in excess both uric-acid and oxalate crystals, the uric acid rather predominated at this time.

The urethra was highly sensitive, especially so in the posterior portion, where it was evidently inflamed to some degree. The prostate was large and boggy; both seminal vesicles were enlarged and engorged with semen and pus, about fifteen to twenty drops of which were expressed by milking the vesicles.

Here was a case rather complicated, to say the least; urethral, prostatic, and vesicular inflammation, with a sensitiveness that made them very intolerent of direct treatment, together with an underlying uric-acid and oxalate excess. I have suspected a possible incipient urinary tuberculosis as lying back of these, but have never obtained any direct evidence to that effect; no bacilli have been found, though often sought for, in the urine.

The progress of this case has been slow and the patience of both patient and myself has been sorely taxed at times, in view of the tendency to relapse on slight provocation; nevertheless, he has been rewarded by great improvement in many respects. At present—and for the last six months or more—he has been free from the urinary

tenesmus, the hematuria, and the various annoying sensations felt in the prostatic region; and his general condition and strength have so far changed that he walks without the ensuing exhaustion that was formerly unfailing after even the lightest exercise of any sort.

The general conduct has been, materially, as outlined for the other cases: systematically, diet and antilithemic medicines and drinks; locally, soothing tonics and sedatives to the inflamed organs, with massages, milkings, and hot or cold applications as indicated. In this, as in the other cases of seminal vesiculitis, I have made use, to advantage, I have thought, of the faradic current of electricity, applied by means of one electrode in the rectum and a sponge over the lower part of the belly, changing its location so as to direct the current through the right and left vesicles alternately.

CASE XV.—Persistent hematuria and nephralgia, with oxaluria, mistaken for malarial infection; with the final passage of a renal calculus.

The following very interesting case occurring in the practice of my friend Dr. Wheeler Bond of St. Louis, was kindly reported for me by him.

Mr. C., American, æt. fifty years, lawyer, married. No hereditary tendencies; habits luxurious—a high liver.

During childhood, in connection with an attack of scarlatina, he had some involvement of the kidneys; and twenty years ago he had a slight attack of hematuria, which lasted only a few days.

Nine years ago he was awakened one morning by severe pain in the renal region. It lasted about two hours and suddenly abated; returned the next day, and after three hours again subsided. These attacks were accompanied by hematuria. Another similar attack occurred five years ago, which, after a week's duration, culminated in a severe renal colic, relieved only by hypodermics of morphin. A few weeks later the hematuria rapidly increased to an alarming extent, the urine becoming thick and almost pasty with blood. As it was accompanied with a chill and fever, the physician in attendance at that time gave him quinin, 25 grains daily: shortly after which both fever and hematuria subsided.

For some time before this, renal calculus had been suspected, and constant vigilance had been observed to detect either it or sandy particles in the urine. But, failing in this, and considering the apparent relief afforded by quinin, and also the fact that some years previously he had had a severe attack of malarial fever, it was concluded that his hematuria and pain were due to the same trouble.

This diagnosis was coincided in by a physician whom he consulted at White Sulphur Springs, Va.

In the fall of 1896 Dr. Bond was consulted, and after a careful and thorough examination, made the diagnosis of renal calculus and oxaluria. He found oxalate of calcium crystals, blood, and pus in every examination of numerous specimens of urine; the latter was passed frequently and in small quantities.

Dr. Bond placed the patient on antilithemic remedies, lithia waters, etc., and a rigid diet, with sufficient morphia to relieve the pain at night. After eight or ten days of such treatment, a mulberry oxalate calculus the size of a grape-seed was passed, per urethram.

Since then, with the exception of times when he oversteps the bounds of moderation in diet, bringing on oxaluric crystals, with urinary irritability and other symptoms of a similar kind, he has been well and free from hematuria and pain.

Dr. Bond's report is concluded as follows: "On several occasions during the last year and a half, it has been clearly demonstrated in this case that the patient's diet has the greatest possible influence upon his urinary symptoms and general health. My experience with his and similar cases gives me positive assurance that the lithemic state is often the cause not only of renal calculus, but of irritability or even inflammatory changes in the genito-urinary tract."

From this report I do not wish to convey the impression that the results of treatment on the basis mentioned have always been ideally prompt and secure, for such an impression would be misleading. The shortness of the time for presenting the cases precludes going into details to the extent of mentioning individual setbacks or slow responses to this or that antilithic medicine, but I have tried to give as fair a general summary of them and their results as possible. And it seems that with such evidence one is drawn irresistibly to a belief in the close and important relationship existing between the pathologic uric and oxalic conditions and many urinary inflammations and disorders commonly met with in practice.

Granted that this is so, however, it must not be supposed that unvarying and immediate success will attend the institution of treatment based on a recognition of such relationship. Many cases I have studied in which the uric or oxalic causal element was suspected, but did not yield to treatment as readily as in those of the foregoing report. But such do not invalidate the deductions mentioned; for one can, of course, recall numerous cases of rheumatism

of various forms that have resisted both medicines and antilithic dietaries of the most approved and, usually, most successful, sort. Still, the rheumatic element was the one working the mischief. And so it is with some chronic urethral inflammations that have been aggravated and perpetuated by a uric- or oxalic-acid predisposition; though these factors may be realized and combated to the best of one's ability, that ability is not infallible by any means, and one is reduced to doing simply the best he is able.

Another feature that has been impressing itself upon me, is that the uric-acid disposition does not always show itself frankly, even in the urine. It may be exercising a baleful influence on a declining gonorrheal urethritis, and yet in such a veiled, obscure way as to elude the watchful observation of the attendant.

One doesn't like to pursue a theme to the limits of faddom, or drop into routine practices, and so it is that this very restraining thought has been the cause of my regretting, in several instances, that I had not given the antirheumatic remedies earlier in the management of a chronic urethritis or epididymitis. Many times I have noted the promptitude with which a few salophen and phenacetin pills would relieve the dragging, heavy pains, or even prevent recurrences of an epididymal inflammation that had begun as gonorrheal.

Within the last few weeks, and since beginning this paper, I have have had additional evidence of the value of looking out for the rheumatic element in dealing with urinary affections. A doctor friend and patient of St. Louis has been under my care for a chronic urethritis for the last six months. I need hesitate the less to say that, and also what follows, since I am the third of St. Louis' specialists who has had turn at treating him.

After the last six-months' course, with the use of scientific dilatings with Kollmann's dilator, endoscopic applications to the granulated bulbous urethral membrane, preceded by argonin injections, etc., the best that could be claimed for the treatment was subjective improvement—lessening of post-urethral burnings; and I was mentally wondering what further could be done that offered any chance of benefit, when the subject of this paper struck me. His urine had never shown oxaluria or any excess of urates that we had observed at the office. Nevertheless, in addition to the local endoscopic treatment, he began to take six or eight tartar-lithin tablets daily; and the next following call at the office showed both subjective and objective improvement, which has been maintained up to the present time

The lessons taught by these cases would seem, then, to be summed up in the following

CONCLUSIONS:

1. Both oxalic and uric acid may appear in the urine either in a physiological or a pathological manner.
2. When pathological, they may exert certain injurious effects on the genito-urinary organs.
3. These effects may be either the inciting of disease where there has been previous health, or they may act by rendering more serious and resistant to ordinary methods of treatment other inflammations and disorders (gonorrheal, etc.) of these organs.
4. The uric-acid element is not always frankly evident as a causal or complicating factor in such cases.
5. And, when recognized, is neither more or less easily controlled than where its disease-manifestations occur in other organs of the body.
6. When either the oxalic or uric element is acting injuriously in the ways mentioned, systemic treatment (dietary, medicinal, and hygienic) is demanded, and may even take precedence over the local measures that are usually considered sufficient in such inflammations or disorders.

1009 Olive street.

A NEW METHOD OF REMOVING POLYPOID GROWTHS
FROM THE BLADDER.

By GEORGE CHISMORE, M.D.

San Francisco

SO far as I know, no one has hitherto undertaken to remove vesicle polypi by the method which it is the object of this paper to describe.

Although my experience is limited to the two cases here reported—purely accidental in the first, entirely intentional in the last—the immediate results—checking a dangerous hemorrhage and relieving an over-distended bladder—were so easily attained, that, whether the cure proves permanent or not, I believe the procedure of sufficient value to bring it to your attention and to recommend it for trial at your hands.

The principle on which the operation is based is that of, by aid of the suction exerted by an aspirator attached to a litholapaxy catheter, or other suitable tube, catching the growth, or growths, in the eye of the instrument, when, by gentle traction and slight to

and fro movements, they are torn from their attachments and drop into the reservoir of the wash-bottle.

To accomplish this I use an ordinary curved litholapaxy tube, of available size, to empty the bladder, then couple on my evacuator, which is so shaped as to fit the hand and give one full control of the point of the catheter; inject two or three fluid ounces of a borated solution as hot as can be borne, to which cocain is added if needed to control the pain. Then systematically go over the interior surface of the viscus with the point of the catheter, at the same time compressing and relaxing the bulb, trying by touch to locate the site of the growth. If the outflow is arrested when the point is in contact with the bladder wall, the instrument is held stationary a few moments, the hand holding the bulb, regulating the amount of suction exerted, then gentle traction, accompanied by a slight sawing motion, is made.

If the occluding body be a polypus it will soon give way and quickly find its way into the reservoir. I find it easy to determine whether it be the healthy wall of the bladder that is caught or not, by the absence of the well-remembered thud and the evidence of pain that all who have done a litholapaxy will recall.

When a polypus is caught the check of the outflow is not nearly so abrupt; there is no expression of pain from the patient, the point of the occluded catheter is somewhat moveable, and not, as in the first case, apparently glued to a fixed spot; besides, in cases of pedunculated tumors the stoppage may take place while the eye of the catheter is not nearly in contact with the bladder wall. It is hard to convey in words the slight variations in the sense of touch, but I was astonished and delighted in my last case to observe how easily and clearly I located the site of the growths, and with what ease the tumors here submitted for your inspection were brought away.

I had supposed from my first case that the growth would have to be large enough to fill completely the eye of the catheter in order to make the suction effective. The second, however, clearly demonstrated that such was not the fact. You will note many small polypi entirely too little to close the eye of the No. 25 F. catheter which I used. Either their bases must have been sessile, several caught at once, or some alterations have taken place in the mucous coat from which they sprung that enabled the suction to exert sufficient power to drag them away.

For reasons that are obvious no estimate of the ultimate results of such an operation can be predicted, but it is contended that enough has been shown to make recourse to this simple and pain-

less procedure justifiable in cases of emergency, where necessary time to remove a patient to hospital, or other preliminaries to more radical measures, are to be gained, particularly in those cases where the bladder is filled with clots, and retention from overdistention is present with its attendant suffering.

CASE I.—On March 21, 1893, I was called, in consultation, by Dr. James F. Sullivan to see W. B. W., aged fifty-two, German drayman, suffering from retention due to clots in the bladder. He had been bleeding profusely *per urethram* for several weeks, was very anemic, cachectic in appearance, and suffering great pain.

The twenty-four hours previous he had passed 1600 c.c., in eight voidings, of dark bloody urine containing large clots; odor of blood, acid, sp. gr. 1026, solid on boiling, one per cent. urea, and containing small pavement cells, blood- and pus-corpuscles.

I introduced a No. 22 F. litholapaxy catheter and by aid of my aspirator broke up and removed about twenty ounces of clot and bright, bloody urine, then partly filled the bladder with hot borated solution containing about four per cent. cocain. While searching for remaining clots I felt a sudden stoppage of the outflow and almost at once it gave way and a small piece of tissue appeared in the reservoir. This was saved and sent to Dr. Douglass W. Montgomery for microscopic examination. He returned a guarded opinion that, "It was not, certainly, malignant."

The bleeding ceased, and the next day Dr. Sullivan reported that it had not recurred. Fourteen days after the patient came to my office, greatly improved in appearance, stating that, "until that morning he had had no trouble; now his urine was again colored." Thinking the styptic effect of the cocain responsible for the arrest of the hemorrhage, I again used the solution as before. Once more the outflow was checked, but this time I was clearly aware that I had caught something. The aspirator was a new one, with a good strong pull; so much so that I thought best to diminish it somewhat by mild compression. After a few moments I made a little traction, when, *plouf*—the obstruction gave way, the bag filled, and a polypus nearly an inch in length and half an inch in diameter dropped into the reservoir.

I saw the patient last July 20, 1893, four months after the first visit and he reported himself well, at work, and not a sign of blood since last operation. I made a brief verbal report of this case at the 1893 meeting of this Association.

In preparing this paper I saw Dr. James F. Sullivan, to learn, if possible, if the relief had been permanent. He reported that he

had not seen the patient since; that he had heard that he had died in the care of an "irregular"—he could not learn when nor from what cause.

CASE II.—P. N. R., aged fifty-nine, French, accountant. Family history contains nothing bearing on his case with the exception of death from a cancer of one sister, aged forty-six. At the age of eighteen he had some "liver trouble," for which he was tapped several times. Was sent to Mexico, where he regained his health and remained well until October, 1896, when he noticed that his urine was cloudy. This led him to consult a physician, who placed him for sixty days on a milk diet and told him he had "kidney disease." During this time, about November 20th, he began to pass bloody urine, which gradually became worse until retention took place, and he came to my office January 14, 1897, in great pain, not having passed a drop of urine in sixteen hours. He was very anemic, with marked cachexia. With a No. 25 F. litholapaxy catheter I drew twenty-four ounces of dark, tarry fluid, looking and smelling precisely like fluid extract of ergot.

Placing him upon the table in my office, with the end of the catheter I easily made out a soft mass in the upper anterior wall of the bladder a little to the left of the median line. Pursuing the method already described, I rapidly removed about a dram or more of tissue, made up of numerous papillomata, upon which Dr. Douglass W. Montgomery reports as follows: "I have examined several slides made both from the tissue sent me on the paper and that in the bottle, and find the growth to be a villous papilloma. Each villus has a delicate core of well-formed connective tissue, carrying numerous thin-walled blood-vessels. The epithelium covering the villi is well and regularly formed, and does not have the appearance of growing with unnatural rapidity, as it frequently has when such a papilloma has undergone, or threatens to undergo, cancerous degeneration. I therefore, from my observation of this growth, would say that it is a villous papilloma of the bladder, showing no evidences of cancerous degeneration."

He went home after the operation, which was quite painless and occupied but a few minutes, but did not regain the ability to evacuate his bladder without recourse to the catheter for several days. There was no more bleeding for eight days, when the urine again became quite bloody. Once more, in my office, I searched the bladder and the site of the former mass appeared quite normal to the touch, but I discerned another patch near the mouth of the right ureter, and again removed a dram or more of the same kind of

tissue. After this he improved rapidly in health and resumed his occupation. There was no more bleeding until March 20th, when there was a slight discoloration, and I again repeated the same measure, this time getting five very small pieces. Since then he has been perfectly free from hematuria, and has apparently quite regained his health and strength.

Society Transactions.

AMERICAN ASSOCIATION OF GENITO-URINARY SURGEONS.

ELEVENTH ANNUAL MEETING, HELD AT THE SHOREHAM HOTEL,
WASHINGTON, D. C., MAY 4, 5, AND 6, 1897.

FIRST DAY, TUESDAY, MAY 4TH.

DR. FRANCIS S. WATSON, *President, in the Chair.*

Before taking up the scientific work of the meeting, the President, Dr. Watson, made a brief address, in the course of which he called attention to the large amount of new and valuable material that is annually contributed by members of the Association to this branch of surgery, a field which, before the Association was formed, was thought to be already quite thoroughly explored and cultivated. He suggested that each year some special subject should be taken up for individual investigation, and the results reported at the next annual meeting.

Report of Post-Mortem Examinations in Some Cases of Movable Kidney.—The President, DR. FRANCIS S. WATSON of Boston, read a paper on this subject.

The paper consisted of a report of the *post-mortem* appearances in eight cases of movable kidney. Four of these subjects were females; four males. In four of them both kidneys were movable. The right kidney alone was movable in three cases; the left kidney alone in one case. The perinephritic fat was greatly diminished in five cases and slightly diminished in two; it was not noted in one. Hydronephrosis was absent in all of the cases. There was ptosis of one or more of the other abdominal organs in six cases; none in two. The peritoneal coverings of the kidney were greatly relaxed in four cases and moderately relaxed in four.

In two of the first four cases, those in which the peritoneum was greatly relaxed, the kidney rotated upon its long or short axis upon turning the body on the side opposite to that of the mobile kidney, or raising the body to an upright position and then bending it far forward. In two others of this group these movements of the organ were prevented by the presence of a number of transverse bands of

peritoneum, which occurred at short intervals and which were the only thing that restrained it.

An interesting point brought to light by these observations was the absence of serious consequences from the movable kidney. In none of them was there evidence of dilatation of the pelvis or the calices of the kidney, or of any organic change that could be referred to the presence of a hydronephrosis during life, and this was as true of those in which the condition was of long standing and the motility very marked as in the others. This fact, Dr. Watson said, he had also observed in five other cases in the living subject on whom he had performed nephrorrhaphy. In one of these cases there was an extensive hydronephrosis, but there was also a renal calculus present, which may have played an important part in establishing this condition.

The speaker said that his observations in these thirteen cases confirmed the view recently expressed by Albarran, that at least in the earlier stages of movable kidney the enlargement of the organ, so often noticed in connection with the crises, is due to acute congestion rather than to retention of urine in the renal pelvis and subsequent dilatation. Albarran based this conclusion upon clinical observations similar to those reported above, and upon the results of experimental ligature of the ureters and the urethra in animals. These experiments showed that the organ enlarged very much, was slightly congested, and that there was but very little urine collected in the pelvis.

The attacks of congestion and an intermittent hydronephrosis, so far as one can judge, arise from a sudden and total obstruction to the passage of the urine through the ureter, caused by a very sharp bend or twist in the latter. Simple descent of the kidney, *per se*, will not produce these. In order that they may occur, one of two things must be present in addition: either the ureter must be abnormally fixed by adhesions at some point in its course, or rotation of the kidney on its long or short axis must take place.

Clinical Observations on Loose and Displaced Kidney.—By DR. JOHN P. BRYSON of St. Louis.

These observations, the speaker said, had been made in the course of operative work in this field, and only represented a synopsis of what he intended to do finally in this connection. The real pathological entity in the condition of loose or displaced kidney, in Dr. Bryson's opinion, was a disturbance in the fatty capsule. Whether or not this was accompanied by a more or less general enteroptosis he could not say. There exists, so far as he had been able to observe: (1) a loosening of the capsule, which allows the kidney to move about within it; (2) the capsule itself may become loosened from its posterior and superior attachments in such a way as to slip about with the kidney; (3) these abnormal conditions may be combined in a greater or lesser degree. He had observed all these conditions in the course of his operative work.

It has been remarked as a common occurrence that the pain in the neighborhood of the kidney is in inverse proportion to the amount

of motility of the organ in the earlier stages. This, he thought, was capable of being explained on these grounds: It is the kidney, and not its vascular pedicle, which first leaves its bed; the first movement would probably be a rotation; that is, the upper border would be rotated forward, and in this way would bend the vascular pedicle. One can easily see how such bending, if it took place near the hilum, would first produce compression of the renal vein, because at that point the artery lies in front, the vein being beneath it, and lying between the ureter and the artery. A twist of the vascular pedicle would cause the artery to press backward on the vein, and thus produce a venous congestion. In this way he could understand the occurrence, in certain cases, of the pain and dragging sensation which these people complain of in the earlier stages.

Next, Dr. Bryson said he had made a few observations in regard to the direction which the kidney took in the cases operated on by him. In two of the cases the change of position was chiefly that of rotation on its long axis, and in those instances the pain was severe. The kidney was so slightly displaced in a downward direction that from observations made prior to the operation he could not have pronounced it a loose kidney. In one instance there was hematuria and the distress was so great that he had felt justified in making an incision which was to some extent exploratory in its nature. The vascular pedicle seemed to be fairly well fixed in both cases, and the whole movement of the kidney seemed to consist of a rotation of the organ on its long axis; he could not account for the pain in any other way than to ascribe it to the bending of the vascular pedicle. In another case he observed that the kidney had not only slipped downward, but also rotated on its shortest axis, so that the hilum was lying almost upward. This was the right kidney in a child nine years of age, and the displacement seemed to have taken place nine months after a fall, the child striking on the loin. The child would frequently wake up at night with a renal crisis, with severe pain in the kidney, running up toward the stomach, and often followed by vomiting. The latter symptom, Dr. Bryson said, he had never observed in connection with disturbance of the left kidney, whether due to calculus, or other cause, while with disturbance of the right kidney vomiting is very common. This fact, to his mind, suggested some connection, anatomically, between the right kidney and the pneumogastric nerve.

Dr. Bryson referred to another case in which the right kidney had dropped down into the lower part of the corresponding inguinal region. It had rotated on its vascular pedicle and on its long axis, so that the posterior or outer border was forward. This rotation was due to the existence of a band of adhesions, which was evidently a part of the fatty capsule. The band was attached about opposite the twelfth rib; above and below it was attached to the kidney on its outer and inferior border, so that the kidney had become twisted on its vascular pedicle and to a marked degree kinked the ureter pretty low down. The patient suffered constantly from pain, which she always described as a dragging pain in the loin. The right loin

was more depressed than the other, a fact which her dressmaker had on several occasions called her attention to. The woman was thirty-one years of age and the mother of three children. After the loin was opened and the kidney thoroughly exposed, it was difficult to tell which was its lower and which its upper border. The kidney was found to be hydronephrotic to some extent, and on this account it was drained through the loin for a time. It was attached high up, and the woman made a perfectly satisfactory recovery; she was entirely relieved of her pain, and to some extent the depression of the right loin was lessened.

The speaker said that, so far as he had observed, a good deal of the pain and distress which comes in these cases of loose kidney is due to the relative looseness and length of the vascular pedicle. In one case where the pain was not severe, but where there was considerable hydronephrosis, with frequency of urination (the latter being due the polyuria), the pedicle was very long. This was on the left side, although both kidneys were more or less movable. In that case he had made an interesting observation with reference to the possible connection of this condition with polyuria. The patient was a young woman, twenty-four years of age, who suffered from polyuria, which became very marked immediately on lying down. She would sometimes have to get up twenty times in the course of the night, usually in the first part of the night. She was slightly nervous, and would probably have been classed as a hysteric by neurologists. When she came to Dr. Bryson's office, after lying down for a short time in the anteroom, she expressed a desire to urinate and voluntarily passed ten ounces of urine, the specific gravity of which was 1010. She was then put on the table and examined; both kidneys were manipulated and replaced in their normal positions, whereupon the patient again expressed a desire to urinate; the catheter was introduced and two ounces of urine withdrawn; specific gravity, 1004. Fifteen minutes later she again wished to urinate and passed six ounces of urine; specific gravity, 1002.

Dr. Bryson said that the symptoms of the cases of loose and displaced kidney coming under his observation had varied much in intensity. In some cases there were no symptoms at all referable to the kidney. In one case, which proved to be a displaced right kidney pressing on the duodenum, the symptoms were entirely gastric in character. The symptoms presented by conditions which seemed to be similar were not always of the same character. In two of the cases the symptoms were apparently due, not to the kidney itself, but to pressure on neighboring organs.

DR. J. WILLIAM WHITE of Philadelphia said that, in the discussion of the interesting theories which may or may not apply to the mechanism of movable kidney, we should not lose sight of the clinical history of these cases. Movable kidney occurs more frequently in women than in men, and is often met with after pregnancy or some exhausting disease, accompanied by disappearance of the fat, or after relaxation of the abdominal walls. Tight-lacing is another factor which probably enters in the etiology of this condition. In

the production of the symptoms, hysteria or the neurotic element possibly played some part. In the cases that have come under his observation there were present more or less vague phenomena, which or might not have been the result of the movable kidney.

The frequent micturition and low specific gravity of the urine in Dr. Bryson's case might have been due to the patient's neurotic condition. He had frequently seen patients who, during a state of mental perturbation, secreted urine very rapidly.

Dr. White said he had seen very few cases of movable kidney on the left side. The gastro-intestinal symptoms accompanying movable kidney on the right side, he thought, were explicable, on the ground that they were due to mechanical disturbance of the duodenum by the kidney displacement. This explanation, he thought, was plausible, although it was possible that the neurotic element played an important part in the production of those symptoms.

Dr. EDWIN C. BURNETT of St. Louis said he had observed a case of renal calculus on the left side in which vomiting occurred after the crisis.

Dr. EDWARD MARTIN of Philadelphia said that recent anatomical researches help to explain why the kidney maintains its position. Cross-sections show that the organ is, to a certain extent, shelved, together with its fatty capsule. This would also explain why tight-lacing would favor the malposition of the organ.

Dr. EUGENE FULLER of New York said he had noted this rapid filling of the bladder in old men, where the organ had been under great pressure from prostatic obstruction. In such a case, when the urine was drawn off, the bladder would sometimes fill again immediately, and this would be repeated perhaps three or four times; it was due, apparently, to the fact that the back-pressure on the kidneys had been relieved. In hydronephrosis he had observed this same phenomenon. In one case coming under his observation the patient suffered from vesical tenesmus and inability to empty his bladder. The urine was drawn off with the catheter and the bladder washed; a few minutes later the man stood up and voluntarily passed fifteen ounces of urine. Subsequently, Dr. Fuller said, he performed nephrectomy on the man and found the left kidney hydronephrotic and the corresponding ureter distended to the size of the small intestine throughout its entire length. This accounted for the rapid accumulation of urine in the bladder.

In some cases of painful kidney, Dr. Fuller said, simply disturbing the capsule seems to effect a cure. He thought many kidneys were movable, with reference to the outer layer of the fatty capsule, no matter whether the kidney itself is movable or not; they are not true movable kidneys.

Dr. GEORGE CHISHMORE of San Francisco said he thought that in many cases polyuria was due to disturbance of the nervous system. In one case coming under his observation a man whose daily output of urine was forty-five ounces, passed on one occasion sixty ounces in one hour as the result of nervous excitation of the kidneys, due to catheterization.

DR. L. BOLTON BANGS of New York said it was not uncommon, especially in women, after some manipulation on the urethra or bladder, to get a profuse discharge of pale urine, of low specific gravity. He had always attributed this to nervous excitability, and he did not think the phenomenon bore any relation to movable kidney.

DR. JAMES BELL of Montreal said he was particularly interested in the fact that hydronephrosis is of comparative infrequency in movable kidney. He had only observed two cases where hydronephrosis was a marked complication. One case was that of a woman fifty years old, who gave a history of renal calculus and had suffered for many years from movable kidney. The second case was that of a man, thirty-five years of age, who had been treated for ten or twelve years for dyspepsia. Finally, a tumor was discovered on the right side, which was thought to be the distended gall-bladder. It proved, however, to be a movable kidney, and nephrorrhaphy was recommended. On exposing the organ, a peculiar form of hydronephrosis was discovered; the pelvis of the kidney seemed to extend completely through the convexity of the organ; the kidney was made up of two masses, separated by a sac of fluid about an inch wide. The fluid was evacuated and the kidney sutured to the loin in such a way as to obliterate the sac. The patient made a good recovery and has since remained well. His dyspeptic symptoms have entirely disappeared.

DR. JAMES P. TUTTLE of New York said he recently saw a patient whose kidneys were so remarkably mobile that it was hardly an exaggeration to say they could be brought together, and yet that patient had no symptoms whatever referable to the kidney. She suffered entirely from gastro-intestinal disturbance. The speaker mentioned an observation made by Dr. Janeway that the more movable the kidney, the less severe are the renal symptoms, while the gastric and intestinal symptoms seem to be correspondingly increased.

DR. GEORGE E. BREWER of New York said he recently had under observation a patient with a cerebellar tumor, who was passing from 40 to 50 ounces of urine daily; the tumor was removed and the quantity of urine immediately increased to about 175 ounces daily; it was rarely less than 150, and the largest quantity passed in one day was 198 ounces. This continued for a month, when the quantity fell to about 100 ounces, where it has since remained. The specific gravity ranged from 1012 to 1024. The constituents of the urine were perfectly normal.

DR. BRANSFORD LEWIS of St. Louis mentioned a case of pyelitis of the left kidney, where, after each crisis, the patient suffers from intense nausea—sometimes vomiting. He referred to another case of right movable kidney, with stone formation, which was accompanied by marked gastric symptoms; there was no hydronephrosis.

DR. BRYSON, in closing the discussion, said that when frequent urination exists in a case of loose kidney, it is important to ascertain whether that symptom is due to renal or vesical irritability.

In all cases coming under his observation, where the patients frequently passed small quantities of urine, and where the bladder was in a healthy condition, he had found the frequency to be due to some disturbance in the lower ureter. In one case where both kidneys were loose, and where frequency was a marked symptom, the lower end of one ureter was found to be tuberculous. The urine was voided in quantities sometimes as small as half an ounce. The speaker expressed the opinion that kinking of the ureter, if it increases the frequency of micturition, must occur low down.

DR. WATSON, in closing the discussion, expressed the view that in the majority of cases of floating or movable kidney, there is a more or less general enteroptosis. This is regarded as an absolute *sine qua non* by Glenard and others. It is rather difficult to conceive of any very marked change in the peritoneal relations of the kidney, which is not associated with some changes in the position of the other abdominal organs as well, notably the stomach.

Some Observations upon the Surgical Anatomy of the Kidney.—DR. GEORGE E. BREWER of New York read a paper with this title.

It was based upon numerous examinations made during the past winter to determine the frequency, causation, symptomatology, and treatment of movable kidney. The total number of cases examined was 351. Of these, 200 were clinical and 151 were *post-mortem* examinations. Of the 200 clinical examinations, 142 were males and 56 females. The total number of displaced kidneys found in the 200 clinical examinations was eleven, or 5.5 per cent.; of these, nine were reported as palpable, one movable, and one floating. In the 142 males, displacement of the kidney was found but twice; in both instances it was the right kidney and was recorded as palpable. The percentage, therefore, of displaced kidney found in the males examined was 1.4 per cent. In the 56 females examined, displacement of the kidney was noted in nine instances, or 17.3 per cent; of these, seven, or 12 per cent., were recorded as palpable; one, or 1.7 per cent., as movable, and one, or 1.7 per cent., as floating; all occurred upon the right side. Of the eleven patients in whom movable kidney was found, only one complained of symptoms which could be attributed to the displaced kidney, and that was a case of floating kidney occurring in a very hysterical female.

Regarding the accuracy of these observations, Dr. Brewer said that in every case recorded as palpable, movable, or floating kidney, he firmly believed that the kidney was felt; that a number of displaced kidneys may have escaped detection he regarded as highly probable, as in many instances, owing to the rigidity of the abdominal muscles, or an excessive deposit of fat, it was utterly impossible to approximate the two examining hands sufficiently to appreciate the presence of an organ of the size of an ordinary kidney and the only sensation conveyed to the fingers was a purely negative one.

Post-mortem Examinations.—Total number of subjects examined, 151. Of these, 91 were males, 56 females, and in four the sex was not recorded. The upper border of the right kidney was found op-

posite the eleventh rib in 78 cases. The upper border of the right kidney was found opposite the twelfth rib in 62 cases; in eight cases it was found one inch below the twelfth rib, and in one case one-half inch below the twelfth rib. The upper border of the left kidney was found opposite the eleventh rib in 100 cases and opposite the twelfth rib in 43 cases; in one case it was found opposite the tenth rib and in the five remaining cases it was found from one-half to one inch below the twelfth rib. One right kidney had been removed, and in one case the left kidney was congenitally absent.

If we consider all kidneys occupying a position below the free border of the ribs as pathological, the number of displaced kidneys found upon *post-mortem* examinations of the 151 subjects was 14, or 9.2 per cent.; ten of these occurred in males and four in females. Of the ten occurring in males, six were on the right side and four on the left. Of the three in female subjects, two were on the right and one on the left.

Dr. Brewer said that the number of observations contained in the above report is far too small to enable one to draw any accurate conclusions from their analysis. The fact that the kidney may be firmly fixed in its normal position after death by no means proves that that kidney was not freely movable during life.

Before concluding his paper, Dr. Brewer called attention to a number of anatomical anomalies connected with the kidneys which were observed during the course of the *post-mortem* examinations, and which were of considerable surgical interest. This is especially true of the great variation found in the distribution of the arteries to the kidney. Eighty-five of the kidneys received more than a single arterial trunk; 70 received two arterial trunks from the aorta, 12 received three, 2 received four, and 1 five. Three of the latter were from the aorta, one from the ovarian, and one from the common iliac. Considerable variation was also observed in the arrangement of the renal, suprarenal, and spermatic veins. A surprising number of variations in the ureter was also observed.

After concluding his paper, Dr. Brewer exhibited a number of photographs illustrating anatomical anomalies of the kidneys.

DR. BANGS said that while making some observations on the kidney in the dead-house at Bellevue two or three years ago, he came across some of the anomalies mentioned in Dr. Brewer's paper.

DR. SAMUEL ALEXANDER of New York said that last winter, while performing nephrectomy in a case of renal tuberculosis, the kidney was found to have an anomalous arterial supply, similar to that in one of the cases mentioned by Dr. Brewer. Fortunately, the condition was observed in time and no damage was done; otherwise, serious hemorrhage might have resulted.

DR. BRYSON said that in some of the anomalous conditions of the kidney and ureter mentioned by Dr. Brewer and illustrated by the photographs, symptoms might have existed during life which would have proved very misleading. For instance, the case where but one ureter entered the bladder, and where catheterization of that ureter

would have brought urine from both kidneys. An important point is the astonishing frequency of these malformations.

DR. EDWARD MARTIN said that, in his opinion, the anatomical importance of Dr. Brewer's paper was almost equaled by its clinical significance. Recently various writers, especially among the Germans, have referred to the ease with which the kidney can be palpated, and he was glad to learn that so careful an observer as Dr. Brewer had so frequently been unable to make it out. This was in accordance with his own experience. Both with and without ether he has been unable to make out the kidney, excepting in a very small proportion of cases.

DR. CHISMORE said the facts contained in Dr. Brewer's instructive paper were certainly of much value to those who deal surgically with the kidney.

DR. J. BLAKE WHITE of New York mentioned a case of nephrectomy, reported by a surgeon, wherein death was due to fatal hemorrhage, the source of which could not be accounted for. The speaker thought it was undoubtedly due to an anomalous arterial supply, which, as Dr. Brewer had shown, is not of infrequent occurrence.

DR. WATSON said he had never been able to palpate the normal kidney, in spite of many attempts.

DR. BANGS said that he also had had extreme difficulty in endeavoring to locate the normal kidney.

Results after Nephrectomy for Renal Tuberculosis.—DR. L. BOLTON BANGS of New York made some remarks on this subject.

He stated that in order to learn the remote results of nephrectomy for renal tuberculosis, and compare them with the results of hygienic measures, he had collected, from the literature and other sources, 112 cases, the majority of which have not been included in any previous report on this subject. His investigation extended back to 1888, when Newman made his report. Since then our methods of diagnosis in these cases have been vastly improved by the aid of the cystoscope and ureteral catheterization. One serious objection encountered was that in a certain number of the cases the remote history could not be ascertained, while in other instances the reports were so vague that no definite conclusions could be drawn.

In all, 112 cases of nephrectomy for renal tuberculosis were collected. The mortality from the operation was about 19 per cent.; adding to this the cases that died within a few months after the operation, we get a mortality of a little over 28 per cent. These figures agree very closely with those of Pollet, who placed the mortality at 29 per cent. Thirty-three of the 112 cases survived for a period varying from one to eight years after the operation; that is, about 30 per cent. Thirty-three were reported as "promising." In 19 there was no remote record of the patient given.

The immediate result of nephrectomy for tuberculosis of the kidney, Dr. Bangs said, may be regarded as brilliant and the prognosis as to the future promising, especially if the affection is of brief duration and confined to one kidney.

DR. GEORGE CHISMORE reported a case of renal tuberculosis which

has been under his constant observation for five years. During that time the patient has been treated on hygienic principles entirely, no operation being performed, with the exception of opening, on several occasions, by puncture, a tuberculous epididymitis, and more recently making a perineal section on account of tubercular perforation of the deep urethra, with extravasation of urine. The patient is now in very good health, and takes care of an extensive business. He passes his urine about twelve times in twenty-four hours, but painlessly. Tubercle bacilli can easily be demonstrated in the urine. His perineal incision has entirely closed. In conclusion, Dr. Chismore said he favored the hygienic treatment of renal tuberculosis in preference to the operative.

DR. EUGENE FULLER said that while, in the main, he agreed with Dr. Chismore, yet there are cases of this affection where the symptoms become unbearable, and where an operation must be performed to give relief.

DR. ARTHUR T. CABOT of Boston mentioned the case of a woman who was supposed to be suffering from renal tuberculosis. There was slight tenderness on one side, some hemorrhage, and an examination of the urine drawn from the corresponding kidney showed the presence of tubercle bacilli. An operation was performed and two very large stones were found occupying the pelvis of the kidney. There were, however, no evidences of tuberculosis. It was possible, Dr. Cabot thought, that the pathologist may have mistaken the smegma bacillus for the tubercle bacillus.

DR. WATSON referred to the close resemblance between the smegma and the tubercle bacillus, and the possibility of this leading to a mistaken diagnosis and prognosis unless the clinical history of the patient was closely observed. In renal tuberculosis he preferred the hygienic to the operative treatment, if the latter could possibly be avoided.

DR. BRVSON mentioned a case of renal tuberculosis, where repeated examinations failed to reveal the presence of the tubercle bacilli in the urine; this was afterward found to be due to the fact that the ureter from the affected kidney was blocked.

DR. BANGS, in closing the discussion, said that in the histories of the cases included in his report, frequent references were made to the smegma bacillus, and in some of the cases the diagnosis of tuberculosis was confirmed by cultures. In many of them the condition of the kidney was clearly tuberculous. In one case of renal tuberculosis at present under his observation, the patient, who positively refuses all operative interference, is gaining in weight and strength, and apparently enjoying good health, although the tubercle bacilli are still present in the urine.

Detection of Stone in the Kidney.—DR. EDWARD MARTIN of Philadelphia read a paper on this subject.

He stated that in making a diagnosis of kidney calculus, the following points should be considered:

1. Family history. Torres has shown that heredity was traceable in two per cent. of cases.

2. Age and environment. The children of the needy are prone to calculi. A damp, changeable climate seems to predispose to their formation, though for diagnostic purposes the fact that many people of a given locality have been affected with stone is of much greater importance than a theoretically unfavorable climatological condition.

3. Traumatism. A history of trauma to the kidney region, particularly if immediately followed by hematuria, and a short or long period of latency of symptoms precedes kidney stone in a considerable number of cases.

4. Diathesis. Lithemia and oxalemia, either actively existent in the patient or as a part of his inheritance, has a bearing on the likelihood of stone formation.

5. Kidney lesions, whether obstructive or otherwise, predispose to stone formation.

6. Mucus. Harrison has called attention to the fact that even in the very early stages of kidney stone there is often, especially in young persons, an otherwise inexplicable abundance of mucus.

7. Blood. Slight transitory hematuria is one of the earliest and most constant signs. The amount of blood is increased by jolting, walking, muscular efforts, or renal palpation. There are rarely clots or bright red blood. Blood cylinders, *i. e.*, casts of the ureters or of the tubules, made up of blood-cells, are frequently found. The red blood-corpuscles are often deprived of their hemoglobin (shadow cells) and show fragmentation. This must be differentiated from crenation, which is not suggestive of the source of hemorrhage. Rayer holds that the blood of kidney stone is most abundant after meals.

8. Crystalline deposits. A large excess of uric acid or urates, oxalates, phosphates, and carbonates, suggests not only the presence of stone, but its nature. The passage of sand or of small concretions is of great diagnostic value.

9. Pus. Pus ultimately develops in most cases of troublesome renal calculi. It is much more common in the early stages of renal tuberculosis than it is in the early history of stone. Blood is also a characteristic of tuberculosis; hence, it may be important to determine whether pus coexists with blood. A large excess of white corpuscles points to coexisting pyuria, thus suggesting tuberculosis rather than stone.

10. Epithelium. The detection of renal cylinders and casts is of course characteristic of kidney irritation. A large abundance of isolated transitional or flat epithelium cells suggests vesical irritation; beyond this, examination of single cells is of little help.

11. Albumen. Probably in the majority of cases in which the stone gives rise to distinct symptoms there is slight albuminuria. To determine whether or not this albuminuria is dependent upon the coexistence of the usual hematuria careful computation and comparison of the amount of albumen and blood present are necessary.

12. Alterations in the quantity and specific gravity of the urine

are common. Polyuria is sometimes constant, often intermittent following an attack of renal colic. Exceptionally, anuria develops with colic, possibly reflex, usually due to the fact that both kidneys are affected.

13. Pain is one of the most constant symptoms of kidney calculus. It may be fixed pain, strictly localized to an area the size of a child's palm and is generally referred to the lumbar region. It is usually aching in character and is made worse by jolting, motion, or direct pressure. It must be acknowledged, however, that pain, though one of the most constant symptoms, is also one of the most misleading, since many renal conditions may produce this symptom with all the characteristics which have so long been regarded as typical of kidney stone. Moreover, it is probable that in nearly fifty per cent. of all cases of kidney calculus the pain is either atypical or is not sufficiently severe to attract the patient's attention.

14. Deep palpation of the kidney region easily elicits distinct tenderness. Excepting in the early stages of stone formation this tenderness is well marked. Dr. Martin said he regarded this as one of the most constant and reliable symptoms. As in the case of pain, it is sometimes referred to the healthy side.

15. Tumor. An appreciable tumor is usually found only after pyonephrosis has developed and multiple calculi of large size are formed.

16. Gastro-intestinal disturbance. This may be either reflex or due to imperfect elimination on the part of the crippled kidneys.

17. Reflex disturbances of the lower urinary tract, such as retention, dysuria, frequent or painful urination, are probably less symptomatic of calculus than of other renal conditions, excepting during and immediately following an acute attack of colic.

18. Palpation. With improved technic palpation of the kidney has become more practicable. The speaker said that in his own experience, however, he has been unable to make out the kidney in a large percentage of cases; the method is likely to be serviceable only in those patients with relaxed abdominal walls and with large calculi.

19. Ureteral examination. This is likely to be chiefly serviceable in deciding which kidney is affected, and if but one is involved, the condition of the other.

20. X-rays. This promises to become our most valuable means of diagnosing (a) latent cases of calculus; (b) those with the regular symptoms; (c) to distinguish between renal stone and such conditions as tuberculosis, acute congestion, Bright's disease, nephralgia, and kidney abnormalities, giving rise to symptoms identical with stone.

Of the symptoms and signs above enumerated, Dr. Martin said he should place in the order of value:

1. X-ray photographs; of these several should be taken with the light placed somewhat differently, before their negative evidence is accepted.

2. The passage of gravel or small concretions, associated with renal hematuria, fixed pain, and colic.

3. Renal hematuria, aggravated by exercise, markedly relieved by rest, remaining long associated with pyuria.

After concluding his paper, Dr. Martin exhibited a number of negatives of X-ray photographs, showing the presence of stone in the kidney.

DR. BANGS said that mere puncture of the kidney in cases of suspected stone is not always conclusive. In one case a small, bean-like stone situated in the pelvis of the kidney was only found after a very careful search with the finger-tip; it was smooth and hard and would easily have eluded the touch of the needle. The diagnosis of kidney stone is sometimes very obscure, and any new method to aid us should be warmly welcomed. Thus far, Dr. Bangs said, he had not had very satisfactory results from the use of the X-rays.

DR. FULLER said the majority of cases of renal calculus which give rise to marked symptoms are those where the stone is small, but too large to enter the ureter, and in such cases he did not think the X-rays would prove of much service. In fact, it is sometimes extremely difficult to find the stone, even after the pelvis of the kidney has been opened. In one such case coming under his observation, wherein the symptoms were very severe, it was necessary to irrigate thoroughly the kidney pelvis in order to dislodge a small particle of stone.

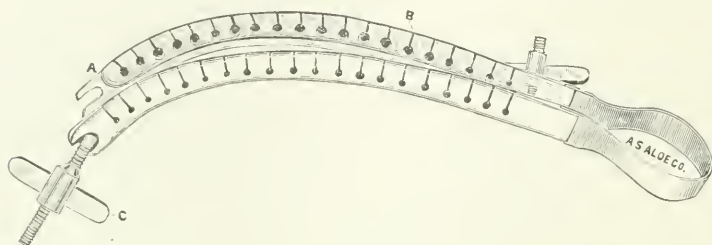
DR. BRVSON said he agreed with Dr. Fuller that the small calculi are the ones more apt to cause trouble. In view of the fact that malformations of the kidney are of such frequent occurrence, a positive diagnosis cannot always be made, and many of these operations must of necessity be of an exploratory nature.

DR. CHISMORE mentioned a symptom of kidney stone which he had found very prominent, namely, pain, radiating down the leg and particularly into the heel on the side corresponding to the affected kidney. The speaker agreed with Dr. Bangs that a failure to find a stone on puncturing the kidney is by no means conclusive evidence that none exists. He advised flushing out the kidney in order to remove small particles of stone.

DR. CABOT said that in one case of suspected renal calculus coming under his observation, four attempts were made to get a photograph by means of the X-rays, but the results were entirely negative. The kidney was then opened, and the entire pelvis was found to be filled with a gravelly mass made up of triple phosphate crystals and held together by tenacious mucus.

A Modified Scrotal Resection Clamp.—DR. BRANSFORD LEWIS of St. Louis exhibited a scrotal resection clamp, modified from the Henry instrument, with the following features: (a) A countersunk slot for the screw shank at the lower extremity of the bar, enabling the operator to throw it out of gear and open the instrument instantaneously for its removal after the resection has been done. (b) Change of the curve of the shanks, making it more fish-hook-like, obviating the projecting lower angle of scrotum left by operating

with the older instrument. (c) Grooving the shanks on their inner, convex surface, making room for the tissues there to take up the infiltration anesthesia fluid. (d) Making the needle openings of the opposite shank funnel-shaped, which materially facilitates the ease and rapidity of introducing the sutures. (e) Widening the shanks, to enable the sutures to take a firmer hold on the wound-edges.



Photographs illustrating the effects of the operation, both immediate and as long as a year afterward, were shown. It was to be understood that the operation was only advisable as an adjuvant to the open method of ligation, and where there was marked redundancy of the scrotum.

DR. J. BLAKE WHITE thought the change in the curve of the shanks in Dr. Lewis' instrument was an improvement on the ordinary scrotal clamp, as it would obviate the necessity of shaving off the lower angle of scrotal tissue.

DR. BANGS said he did not see that this instrument possessed any particular advantage over the Henry clamp. When the operation is properly done with the latter, it does not leave any scrotal tissue to be shaved off.

DR. R. W. TAYLOR said he saw no object in modifying an instrument for an operation which is virtually discredited. Clinical observation had shown that if the varicocele is allowed to remain, elongation of the scrotum will recur.

DR. FULLER said if the veins are obliterated the scrotum will gradually regain its tone without ablation, although in some instances both procedures may be necessary.

DR. MARTIN agreed with Dr. Fuller that in some cases it was necessary to obliterate the veins and cut off a part of the scrotum as well. One disadvantage of using the clamp is that after putting in the stitches and taking it off the scrotum is apt to fill up with blood, which forms clots and retards healing.

DR. BANGS said that ablation of the scrotum in many cases is necessary; obliteration of the veins alone will not suffice. The combined operation gives a very satisfactory result.

DR. LEWIS, in closing the discussion, exhibited the photograph of a case where the veins were obliterated by the open method without producing any improvement in the condition of the scrotum. In performing ablation of the scrotum he has always obtained primary union, and has never seen any blood-clots form in the scrotum. The

operation can be done under infiltration anesthesia with absolutely no pain.

A Case of Cystin Calculus in the Male Bladder.—DR. PAUL THORNDIKE of Boston reported the case of a man, forty-three years old, from whose bladder a cystin calculus weighing three and one-half grams was removed. The man's clinical history extended over a period of five years. The urine usually had a very disagreeable odor, due to the evolution of sulphuretted hydrogen gas. The case was of intense interest because of the rarity of this kind of stone, and because of the fact that it was only after repeated efforts that cystin crystals were found in the urine.

SECOND DAY, WEDNESDAY, MAY 5TH.

Urethro-Rectal Fistula.—DR. JAMES P. TUTTLE of New York read a paper with this title.

He first reviewed the literature on this subject, and referred to the comparative rarity of the condition, which consists of a fistulous tract between the urethra and the rectum.

Urethro-rectal fistulæ may be classified, according to their causes, into traumatic and pathological. The most frequent cause of the traumatic variety is cutting or tearing into the rectum during operations upon the urethra, prostate, or for stone. Among the pathological causes he mentioned cancer and the various forms of ulceration of rectum, either simple, tubercular, or syphilitic. Diseases of the urethra and prostate are the causes of a large majority of urethro-rectal fistulæ. Stricture, with posterior ulceration, is perhaps the most frequent in its causation. Abscesses of the prostate, whether simple, gonorrheal, or tubercular, may result in this form of fistula. Calculi of the prostatic or membranous urethra, or those developing in the prostate gland itself, may be the exciting cause of recto-urethral fistula. Congenital urethro-rectal fistulæ have been observed a number of times; these, however, are not true fistulæ, but malformations.

The treatment of urethro-rectal fistula has been as various as it has been unsuccessful. Few authors, indeed, have had the temerity to advise any methods as certain, the most being content with suggesting palliative remedies, and possible surgical procedures in which they have little confidence. The principles underlying the successful treatment of these fistulæ may be briefly stated, and differ very little from those laid down by Duplay.

1. Remove all obstruction to the passage of urine or intestinal contents through the normal channels. This involves the treatment or removal of rectal or urethral stricture, polypi, or other tumors, and the overcoming of sphincteric spasm and obstruction at the anus.

2. Protect the parts from the abnormal passage of urine or fecal matter and gas.

3. The therapeutic and surgical treatment of the fistulous tract itself.

The application of stimulating agents or cauterization should be patiently tried before resorting to more radical measures.

After describing the various operations that have been resorted to in these cases, Dr. Tuttle gave a brief report of three cases of urethro-rectal fistula coming under his care. In the first case the fistula opened into the rectum about half an inch above the external sphincter, and was large enough to easily admit the end of the index finger. The floor of the urethra was absent to a considerable extent, and required to be rebuilt. There was considerable, though not excessive, connective-tissue deposit about the opening, and a stricture of the membranous urethra anterior to the fistulous opening. After several days' preparation and treatment to sterilize the urinary and intestinal secretions, he operated, on August 30, 1896, as follows:

The sphincter was thoroughly incised and all the cicatricial tissue cut away with scissors, thus freshening the edges of the fistula at both ends. The intestinal wall was then dissected from its anterior attachments up to a point three-quarters of an inch above the fistula and half an inch to each side. The stricture of the urethra was then operated on by perineal section, the incision being carried backward into the fistulous opening. A flap was then dissected from the soft tissues at either side of the urethra large enough to replace that portion of the floor which had been destroyed. These were sewed together with catgut sutures over a full-sized sound, introduced through the meatus in order that the caliber of the canal might be accurately re-established and no pocket left. The fistula being thus closed, the sound was withdrawn and the fresh perineal wound and anterior incision in the urethra left unsutured. The edges of the intestine were then sewed together with chromicized catgut and the rectum packed with iodoform gauze, a drainage tube having been introduced for the escape of gas. A soft No. 12 catheter was introduced into the bladder through the meatus and fastened there. The perineal incision was loosely packed with absorbent gauze and dressed with an ordinary T-bandage. It seemed to cause no inconvenience, and was left in for eighteen days, the bladder and perineal wound being irrigated daily with Thiersch's solution. Convalescence was uneventful, the perineal wound healing in about six weeks. The patient left the hospital December 1, 1896, perfectly well.

Two other cases were reported by Dr. Tuttle in which the operation proved successful.

DR. EUGENE FULLER said that in a very aggravated case of urethro-rectal fistula which came under his care last summer, he had operated as follows: A circular incision was made around the gut outside the sphincter, and the gut dissected up on all sides for a distance of about three-quarters to one inch above the fistulous opening between the urethra and the bowel; he then twisted this loose gut around to an angle of about ninety degrees, and stitched it there to keep it in place; a tube was then inserted into the bowel. The sphincter was cut up to the opening of the fistula. Previous to the operation the man was bedridden, and the feces continually blocked the urethra. At present he is up and about, and very comfortable,

although he still has a small perineal fistula, which is due to the fact that the drainage-tube was left in for too long a time by mistake. Dr. Fuller said he was unable to learn the cause of the fistula in the above case, although it was probably due to traumatism. There was no stricture of the urethra.

DR. SAMUEL ALEXANDER called attention to the fact that these cases not infrequently relapse after operation. He had seen two such instances. Personally, he had been very unsuccessful in operating on this class of fistulæ, and he thought that a good result in many instances was due to the fact that the fistula is a very small one and that there is not a great amount of cicatricial tissue. He congratulated Dr. Tuttle upon his success.

DR. J. BLAKE WHITE said there are a number of important elements which should be borne in mind in the treatment of the condition under discussion. One is to prevent the urine from coming in contact with the wound, as even one drop may spoil the result of the operation. In urethro-rectal fistulæ of traumatic origin an operation would be much more likely to prove successful than in those cases where it is the result of a syphilitic or tubercular infection.

DR. BRYSON said he agreed with Dr. White that the etiology is a very important factor in the prognosis of these cases. He could only recall two cases of urethro-rectal fistula which were not of tubercular origin. The latter cases were not (excepting in one instance) complicated with stricture, and all means employed failed utterly in giving them relief. In some cases suprapubic drainage was instituted for a time, but without any benefit. Dr. Bryson said that when a stricture of the urethra exists in these cases, it should be dealt with before any other and more serious operation is undertaken, especially if there is no loss of substance and the case is non-tubercular in character. By removing the stricture we give the fistula an opportunity to heal.

DR. TUTTLE, in closing the discussion, said he was fully in accord with the opinions expressed that certain of these cases, where the condition is due to tuberculosis and there is much loss of tissue, are incurable by any method. He fully agreed with Dr. Bryson that where a stricture of the urethra exists, it should be carefully removed before any attempts at plastic surgery are made. In addition to that, permanent catheterization should be tried. In the third case reported by him there was a stricture of the rectum, which was thoroughly removed, but this did not relieve the fistula at all. While all these preliminary measures should be tried, they usually fail to produce a cure. This has been the experience of Sir Henry Thompson and others who have written on this subject. When the cicatricial tissue has once become deposited between the mucous surfaces, Dr. Tuttle said he did not think the case could be cured until that tissue is removed and the obstruction at both ends—both rectum and urethra—has been relieved.

Priapism.—DR. R. W. TAYLOR of New York, read a paper on this subject. He stated that this affection may be divided into the following classes:

1. Priapism observed in infants and children, induced by reflex action, in cases of long, tight, adherent prepuce, of stone in the bladder or prostatic urethra, and of worms in the rectum.

2. Priapism in adult subjects, symptomatic of stone in the bladder, stone in the prostatic urethra, stricture, cystitis, and observed during retention. In these cases the uneasy or painful sensation is felt in the glans penis, while the body of the organ usually is only moderately congested and sometimes curved downward or laterally. This condition disappears upon the removal of the cause.

3. Priapism symptomatic of gonorrhea, with perhaps involvement of the corpus spongiosum and downward curvature. This condition is painful and transitory, and may occur several times during the night. In cases of downward curvature of the penis due to inflammatory engorgement of the corpus spongiosum and spasm of the musculature of the urethra, the term *chordee* is applied.

4. Priapism due to the ingestion of cantharides, which is a form that is seldom or never seen now, since this drug is so rarely used in medicine.

5. Essential priapism. The latter form, which was the only one considered by the author, may be divided into four varieties:

a. Priapism caused by injury to the spinal cord (either high up or low down) and by blows or violence inflicted upon the perineum.

b. Priapism which is a symptom of cerebral or descending spinal cord disease.

c. Priapism which occurs after alcoholic and sexual excesses; and,

d. Priapism which comes on a person in ill health, in whom it is difficult to obtain data as to local injury and causation, and in which cases there is now a tendency to look upon leukemia as the etiological factor.

Prognosis.—Few definite statements can be made as to the prognosis of priapism of any form. In those cases in which injury to the corpora cavernosa or thromboses can be made out, incisions may greatly expedite the cure. The existence of spinal disease necessitates a guarded prognosis. In very much run-down neurasthenic subjects, in sexual perverts, and those suffering from leukemia, the chances are that the priapism will be very persistent and that relapses are apt to occur.

Treatment.—In surveying the results of treatment of the cases of priapism already published, one is forced to the opinion that nothing like a routine method can be laid down. This much, however, can be stated with emphasis. Chloroform narcosis has failed in every case in which it has been used. Ice usually does more harm than good; electricity has no value and may even be harmful, and leeches to the number of sixteen and forty have failed to produce any amelioration in the condition of the penis and have been injurious in their depletory effects.

The speaker said that his own preference in dealing with these cases is to resort early to moderate and tentative incisions into the most turgid part, or into parts which are the seat of continuous pain,

or into nodular masses in all probability the result of traumatism. It is always good practice in priapism to use either the potassium salt alone or in combination with mercury, when a history of antecedent or present syphilis is elicited. A number of cases are on record in which the condition was relieved by potassium iodid. Bromid of potassium, chloral, belladonna, and morphin may be of benefit, especially during paroxysms. Hot baths, hot and cold spinal douches, sponging with hot water, spinal cauterization, anodyne poultices and perhaps ice-bags may be found beneficial, but the latter must be guardedly used. Any ephemeral or systemic disorder should receive appropriate treatment.

DR. BRANSFORD LEWIS reported the following case of priapism, of a moderate degree, which recently came under his observation: J. W. F., aged thirty-five, single, a clerk. The family history was negative, excepting that both grandmothers and one maternal aunt had died of consumption. The man was first seen in September, 1895. He had never had any serious illness and appeared to be enjoying fairly good health. He was evidently a neurotic and avoided the society of women. He had been operated on at various times for varicocele and hydrocele and had also been circumcised. After this he complained of frequent semi-erectons, due to the rubbing of his clothing against the glans. These erections were apparently unaccompanied by any sexual desire or provocation, and this condition persisted for two years, notwithstanding his endeavors to be relieved. He asserted that he had never had sexual intercourse, his aversion to women precluding it. Dr. Lewis said he chanced to witness one of these semi-erectons, and in order to prevent their repetition he ligated the dorsal artery of the penis on each side, the operation being done under infiltration anesthesia. A month later the man reported that the operation had proved quite satisfactory. Since then he had not been heard from.

DR. J. WILLIAM WHITE said that Dr. Taylor's paper on this subject was the most comprehensive he knew of. In some of these cases, where there is an exudate which constitutes a mechanical cause of the priapism, it might be well, if other measures failed, to try thyroid extract. The speaker said he had employed this remedy successfully in removing an hypertrophied cicatrix on the face, which on account of its conspicuousness was very annoying, and which excision would probably have made worse. He felt confident that thyroid extract modifies the nutrition and causes absorption sometimes to a remarkable degree. It has been successfully used in ichthyosis and psoriasis. Dr. White said he had also employed the remedy in a case of indurated plaques in the corpora cavernosa, but in that instance it proved unavailing.

Chronic Contraction of the Prostatic Fibers Encircling the Vesical Neck.—DR. EUGENE FULLER of New York read a paper with this title. He stated that the condition to which he referred as chronic contraction of the prostatic fibers encircling the vesical neck represented a pathological change in the part, and was totally different from what the French writers (Civiale, Roux, Velpeau and others)

have termed "neuralgia of the vesical neck," or "contraction of the vesical neck." The chronic contraction to which he referred, however, bears a relationship to the functional one in that it represents a pathological state which may apparently result from functional contraction or spasm in cases where, owing to some settled disorder of the sexual apparatus, the rectum, the kidney, or other organ, functional contraction of the vesical neck has existed as a prominent symptom for a long period. The contraction is permanent, rigid, and does not relax even under profound anesthesia. If a perineal incision is made in such a case, and the finger passed into the membranous urethra in an attempt to enter the bladder, the finger-tip will find itself tightly engaged in a ring-like contraction in the deepest portion of the prostatic urethra, where under normal circumstances the canal should be wide, funnel-shaped and elastic, merging itself into the vesical cavity in such a manner that it is impossible simply from the feel to determine just where the urethra ends and the bladder begins. The presence of such a contraction, however, cannot be detected by means of a good-sized sound passed through the urethra. If the surgeon feels carefully with the finger-tip he will discover the urethra just in front of the circular contraction to be roomy and somewhat pouched. The mucous membrane of the entire portion of the deep urethra will ordinarily feel perfectly normal and free from any evidences of previous inflammation. The condition is not associated with prostatic hypertrophy. After the contraction has been thoroughly ruptured or cut through, little evidence will be left to the touch to indicate the nature of the lesion which previously existed. Dr. Fuller said he had thus far been unable to procure an histological examination of the unusual condition, as all of his patients suffering in this manner had recovered as the result of operation.

The clinical symptom prominent in cases of this nature and in fact it might be said the only true symptom dependent on the lesion itself was an inability, either complete or partial, to void urine. This inability is of gradual development, and may at first be intermittent in character, but after a time it becomes permanent. Next in order the patient experiences temporary attacks of complete retention. For a number of hours he may be unable to urinate. Early attacks of this nature may pass off of themselves as a result of rest, sitting in hot water, etc., but after a time it will be found necessary to employ a catheter and empty the bladder on one or several occasions before nature will reassert herself. Finally, all power to urinate naturally is lost and permanent recourse to the catheter is necessary. If pain or other symptoms be present, they are due either to the existence of some disorder of the sexual apparatus, kidney, etc., which has acted as the originator of the trouble at the vesical neck, or else to vesical infection, which has resulted from instrumentation or stagnation of urine due to the retention. This train of symptoms is of slow development.

A diagnosis of this condition has to be made largely from the clinical history of the case, together with an exclusion of other causes which may produce impediments to urination.

The only treatment for chronic contraction of the prostatic fibers encircling the vesical neck which, in the writer's experience, had shown any favorable results consists in thoroughly rupturing or cutting through these fibers. This can be accomplished by means of the finger or the knife, as the case may be, introduced through a perineal incision. Perineal vesical drainage should be practised after the operation. This treatment in his hands has been followed by complete disappearance of all subjective symptoms.

Dr. Fuller then detailed the histories of four cases of this affection coming under his observation in which an operation was required to relieve the patients.

DR. CHISMORE said that Dr. Fuller's paper very accurately described a condition which he had met with on several occasions. In all of those cases, with one notable exception, the result of operative measures was as stated by the reader of the paper. The exceptional case was that of a wealthy gentleman who suffered from some obscure trouble in the bladder or in the region of the bladder for which he underwent the usual run of treatment, sounds, lavage of the bladder, etc., in spite of which he gradually grew worse and the intervals of micturition became shorter. He first came under Dr. Chismore's observation about six years ago. A careful examination failed to reveal any reason for the man's suffering. Complete cessation of all local treatment was advised for a time, and this not proving of any benefit, perineal section was performed. Precisely the condition described by Dr. Fuller was found. The finger was forced through the contracted vesical neck, which produced such a shock that the man almost died on the table. The contracted fibers were freely divided, so that the finger could slip through without any difficulty. Vesical drainage was continued for two weeks, after which the perineal wound was permitted to close. The operation gave some little relief and the man improved for a time in general health. He relapsed, however, and traveled all over the world looking for relief. Morris of London, suggested cutting down on the right kidney. This was afterward done, but nothing was found, and his symptoms have practically remained unchanged. The man is certainly neurotic, and the only pathological change that could be discovered was the stricture at the vesical neck above referred to. The seminal vesicles do not appear to be diseased, at least not to any marked extent. In this instance the free division of the contracted fibers did not relieve the patient to any considerable extent. The man has never found it necessary to use the catheter; he has never had any difficulty and scarcely any pain in passing his water. His chief difficulty is the frequency with which he is obliged to micturate. Dr. Chismore expressed the opinion that the neurotic element played an important part in the production of the symptoms in this case.

DR. ALEXANDER said that this condition of contracture of the prostatic fibers had been first called to his attention by Dr. Keyes, and a number of such cases had come under his observation. His own conviction was that the condition did not consist merely of an affection of the fibers alone, but of the whole substance of the prostate,

and that the muscular contracture of the bladder was the active way in which this morbid condition of the prostate manifested itself. The sudden attacks of retention he thought to a great degree were the result of congestion. Clinically, he had recognized three distinct forms: first, when the tissues at the vesical neck are soft and elastic, and it does not require much force to pass through them, although they are distinctly harder than the normal tissues. Second, when the finger meets with some resistance, which, as pressure is made, suddenly gives way; and, third, a firm, fibrous condition through which it is sometimes impossible to pass the finger. Complete division of the fibers in this class of cases is not always as harmless a procedure as might be inferred from what has been said. Three cases had come under the speaker's observation where incontinence of urine followed. In cases where the vesical symptoms, tenesmus and contracture at the neck of the bladder, are associated with renal disease, the relief of the later does not help the vesical symptoms. In one case of this kind, where a stone was removed from the kidney, the vesical symptoms remained unchanged until a perineal prostatectomy had been performed.

In conclusion, Dr. Alexander said that his own experience, contrary to that of Dr. Fuller, had led him to associate this vesical condition with persons who had suffered from sexual irregularities, with congestion of the prostate, or with inflammatory conditions involving the prostatic urethra.

DR. J. WILLIAM WHITE said he had been struck with the resemblance of this condition, as described by Dr. Fuller, to ordinary stricture of the urethra. If we admit the inflammatory origin of the phenomena, we have a group of symptoms which are analogous to those referable to stricture of the anterior and deep urethra.

DR. BRYSON said it was to be regretted that Dr. Fuller had thus far been unable to study the condition pathologically. It would be interesting to learn just exactly of what these contractures consisted, whether of a hypertrophy of the tissues normal to the parts, or of a deposit of abnormal, cicatricial tissue. We all know that the sphincter vesicae is composed largely of fibrous tissue. At the meeting of the Association in Newport several years ago Dr. Bryson said he had reported three cases exactly similar to those described by Dr. Fuller: two of those patients had since died of tubercular disease. In all of the cases observed by him, the prostatic urethra immediately in front of the fibrous ring was roomy, and the ring itself seemed to correspond with the involuntary sphincter of the bladder.

Dr. Bryson said that an interesting point brought out by the paper was the relationship between kidney disease and these vesical manifestations. He did not believe that we get any frequency of urination nor any symptoms of vesical tenesmus unless there is involvement of the lower third of the ureter. We are constantly seeing cases of stone in the kidney which cause disturbance sufficiently severe to impair the general health and yet there are no vesical symptoms, so that he would be inclined to look carefully for a ureteritis when there is an extension of the symptomatology to the bladder.

DR. BANGS said he was inclined to think that the cases described in Dr. Fuller's paper are of quite common occurrence—so common that in his teaching and in some of his papers he had called attention to this condition of contracture at the neck of the bladder. The etiology has been in his mind traceable to some antecedent inflammation or disturbance of the prostatic urethra. In one case it occurred after an attack of typhoid fever in which the bladder and deep urethra had been infected by a catheter introduced to relieve retention. Usually, he has associated it with some sexual irritation or some disturbance of the prostatic or neighboring urethra. Another observation has led him to the conclusion that where there is a loss of harmony between the circular and detrusor fibers, with residual urine, the cases are not cured until the bladder is drained and harmony restored between the different muscular parts of the organ.

DR. CHISMORE mentioned a case, verified by *post-mortem*, where this condition of the tissues of the prostatic urethra, which had apparently existed for many years, finally degenerated into fatal cancer.

DR. FULLER, in closing the discussion, said that this contracture of the prostatic fibers was not a rare condition and had been noticed by a number of observers, but the cases had never been systematized and little attempt had been made to ascertain their etiology. While there was no doubt that in many of these cases a neurotic element was present, care should be taken not to operate in a case where the vesical symptoms are entirely due to a neurosis. In reply to Dr. White he said that while this condition might be defined by some as a stricture, still that term would not be strictly correct. It is a narrowing of the urethra which cannot be detected by the passage of a sound. Dr. Fuller said that while incontinence may result from the operation, it is usually only temporary. All operative interference should be avoided in a case where there is a suspicion of locomotor ataxia. In cases where there is a kidney lesion, with retention, it is well to operate on the kidney first, as that may relieve the vesical symptom if the retention is simply due to spasm.

Tubercular Necrosis of the Prostate¹.—By DR. EUGENE FULLER of New York.

The author stated that tuberculosis in connection with the prostate is spoken of in most text-books as of common occurrence. Most of those writers, however, use the term "prostate" very loosely, it being made to include besides the prostate proper, the neck of the bladder, the deep urethra and the seminal vesicles, together with their ducts. Dr. Fuller expressed the opinion that while tuberculosis in connection with the deep urethra and the genital tract is of common occurrence, tuberculosis of the prostate is rare. In tuberculosis connected with the seminal vesicles the loose connective tissue enveloping the sacs becomes infiltrated with a hard inflammatory exudate which appears to the finger-tip introduced into the rectum as a firm tumor of considerable size. A surgeon, on feeling such a mass, almost invariably pronounces it prostatic enlargement. If, however, a dissection be made in a case of this description, the pros-

¹Will be published.

tate itself will in most instances be found normal, although encased, as it were, in the inflammatory exudate which has been thrown out about the diseased seminal vesicles, and which has extended itself into the meshwork of the fibrous structure forming the capsule of the prostate. Tuberculosis in connection with the deep urethra tends to extend itself along the ejaculatory ducts and into the seminal vesicles rather than into the prostate. Still, in cases where tubercular ulceration of the prostatic urethra occurs, the portion of the gland lying next the urethra becomes secondarily involved by the ulcerative process, which may and rarely does extend so as to eventually cause its total destruction. Very infrequently tuberculosis may attack the prostatic body primarily and independently of the deep urethra or the genital tract.

DR. CHISMORE said that Dr. Fuller's observations were wholly in accord with his own. Most of the text-books on this subject state that tuberculosis of the urogenital tract will sooner or later involve the prostate. Such had not been his experience. In cases where instrumentation has been avoided there is usually little or no involvement of the prostate or of the tissues in its immediate vicinity. In one case coming under his observation the tubercular disease almost surrounded the prostate, and yet that organ was not involved.

DR. ALEXANDER said that tubercular necrosis of the prostate alone does occur at times, without any involvement of the mucous membrane either of the bladder or prostatic urethra, and the ulceration may find its way into the rectum without any injury to the urethra. During the past year he saw one such case. The patient was a man sixty-five years of age, whose condition was first diagnosed as prostatic enlargement. There was complete retention and the man was dependent on the catheter. He left the hospital, but returned three months later with an opening from the rectum through the capsule of the prostate through which the finger could be introduced and swept around. The *post-mortem* revealed a tuberculosis which was limited entirely to the prostate, the seminal vesicles, bladder and urethra not being at all involved. There was also consolidation of both lungs.

DR. BANGS said that Guyon and others had called attention to the possibility of tubercular foci in the prostate without any involvement of the seminal vesicles.

A New Method of Removing Polypoid Growths from the Bladder.—By DR. GEORGE CHISMORE of San Francisco.

The speaker said the method was discovered by him accidentally. It consists of the introduction into the bladder of a litholapaxy catheter attached to an aspirator; by means of suction the growths are caught in the eye of the instrument, and by gentle traction and slight to and fro movements they are torn from their attachments and drop into the reservoir of the wash-bottle.

The method employed by Dr. Chismore is as follows: He uses an ordinary curved litholapaxy tube, of available size, to empty the bladder; he then couples on the evacuator, which is so shaped as to fit the hand and give one full control of the point of the catheter; he

then injects two or three ounces of a borated solution, as hot as can be borne, to which cocain can be added if desired. He then systematically goes over the interior surface of the bladder with the point of the catheter, at the same time compressing and relaxing the bulb, trying by touch to locate the site of the growth. If the outflow is arrested when the point is not in contact with the bladder wall, the instrument is held stationary a few moments, the hand holding the bulb regulating the amount of suction exerted; then gentle traction accompanied by a slight sawing motion is made. If the occluding body be a polypus it will soon give way and be washed into the reservoir. This method of removing polypi, Dr. Chismore said, he considered justifiable in cases of emergency, until more radical measures can be resorted to. It is particularly valuable in those cases where the bladder is filled with clots, and retention from over-distension is present with its attendant suffering. The author then reported two such cases in which he had employed the method with entire success. He also exhibited a number of polypi removed by this means.

DR. BANGS said he was quite familiar with Dr. Chismore's instrument, having often employed it in doing litholapaxy. The removal of polypi from the bladder with the tube of the instrument was an addition to its usefulness which was very interesting. We all know that there is more than one way of curing these papillomata of the bladder—using the word "cure" in the sense of giving immediate relief. For this purpose he had employed applications of hot boric-acid solution with very good success. In one case the papilloma shriveled up under this treatment, and there had been no recurrence up to the present time, a period of about two years.

DR. BRYSON said that personally he had never seen a papilloma of the bladder which did not eventually prove to be malignant, although they doubtless began as non-malignant growths.

DR. FULLER expressed the opinion that the method of treatment described by Dr. Chismore might be advantageously used in combination with the cystoscope. The latter would first give us an idea as to the size of the growths, and suggest the proper method for their removal. In some cases he thought a more radical operation than the one suggested by Dr. Chismore was indicated.

THE PRESIDENT, DR. WATSON, reported a case of vesical papilloma coming under his observation where he had performed three operations—one perineal and two suprapubic—for their removal at intervals of one year, eighteen months, and two years. The man then consulted a so-called spiritual medium, who gave him some medicine which he stated had caused him to pass a number of the growths spontaneously. Dr. Watson said that in those cases where the growths were pedunculated, he thought Dr. Chismore's method might be employed to advantage, but where the growths were large or sessile, more radical measures would probably be called for. He was rather surprised to hear that there was so little hemorrhage after the operation employed by Dr. Chismore. Personally, he preferred

to have the bladder open, so that any severe bleeding could be promptly checked.

DR. CHISMORE, in closing the discussion, said his chief object in bringing up this matter was to show how easily these growths could be removed by this method in some cases, particularly those of the pedunculated variety. He did not offer it as a substitute for more radical measures, but it would often prove of value in an emergency, as, for example, when we are called to a case of this kind at night, when a radical operation is impracticable. Instead of producing hemorrhage, it checks it.

A Case of Recurrent Stone in the Bladder of a Child.—Reported by DR. WILLIAM JUDKINS of Cincinnati.

The patient was a boy, who, when he first came under Dr. Judkins' observation, three years ago, was seven years of age. At that time he presented symptoms of stone in the bladder, and a calculus, weighing 93 grains, was removed by suprapubic cystotomy. Five months later the child again began to complain of symptoms which pointed to vesical calculus, and in July, 1894, seven months after the first operation, median lithotomy was performed and a second stone, weighing 85 grains, was removed. Neither of the stones was faceted. An interesting point in connection with the case was the rapidity with which the second stone formed.

A Case of Nephrectomy for Cystic Adenoma in a Pregnant Woman.—By DR. CHARLES L. SCUDDER of Boston, Mass.

The patient was a woman nineteen years old, who was first seen in January, 1891. She complained of a continuous dragging pain in the left side of the abdomen and of a movable tumor in that region. Examination disclosed a slight fulness in the left lumbar region. This corresponded to a mass within the abdomen, about the size of a normal kidney. There was no frequency of micturition. The urine was of a specific gravity of 1022; it contained a trace of albumin and hyalin and granular casts. A diagnosis of movable kidney was made. The patient used a truss for several months with considerable relief to the pain.

In March, 1894, it was found that the tumor in the left lumbar region had increased to the size of three fists, and was growing rather rapidly. The woman at this time was three-months' pregnant. The tumor was aspirated and some fluid withdrawn, which contained, among other matters, a large quantity of bile. A few days later nephrectomy was performed, the left kidney being removed. The right kidney was found to be normal. The mass removed was submitted to Dr. W. F. Whitney, of the Harvard Medical School, for pathological examination; he reported that it was "a cystic adenoma of the kidney, with a tendency to a hyalin degeneration of the contents."

The woman went on to full term, and was delivered without any complications of a living child. Three years have elapsed since the nephrectomy was performed; the woman is enjoying good health and about ten months ago was delivered of a second child.

The case, Dr. Scudder said, was of interest for several reasons.

It is unusual to find bile pigment in a cyst of the kidney. The operation did not interfere with the completion of gestation. The second pregnancy was normal in every respect. It required seven days after the operation for the remaining kidney to secrete what now is the normal amount of urine, namely, about 900 c.c.

Report of a Case of Hernia Testis.—By DR. G. W. ALLEN of Boston, Mass.

J. C., twenty years of age, came to the Boston Dispensary on February 20, 1897, with a long continued gleet and what appeared to be an ordinary epididymitis of three-weeks' duration. Four days later a prominent swelling, as large as a hazelnut, was seen over the front of the testicle. It was conical in shape and the overlying skin appeared tense and thin. It resembled a tubercular abscess of the epididymis. Upon incision there was a very slight flow of thin pus and a bulging out of soft, yellowish, gray, spongy tissue, which suggested testicle and proved to be such. Some sloughing of the testicle and the skin continued and the former gradually protruded more and more for two or three weeks, by which time the sloughing tissue had separated and a very slow process of repair had set in, which, however, is not yet complete. The incision was enlarged, and several unsuccessful attempts made to cover over the testicle with sound skin. The cavity of the tunica vaginalis gradually filled up with granulations, and there is now a simple granulating surface, as large as a five-cent piece, with a small area of testicle in the center. A month after the patient's first visit a sore appeared on the prepuce which became indurated in due time and was followed by a secondary roseola. This apparently excludes syphilis as a cause of the orchitis. No evidence of tuberculosis could be discovered.

THIRD DAY, THURSDAY, MAY 6TH.

A Possible Aid to the Discovery of the Tubercle Bacillus in the Urine.—DR. JOHN P. BRYSON of St. Louis read a paper on this subject.

He stated that in the course of his routine work some time ago he had accidentally discovered that when tubercle bacilli were present in the urine, they were much more abundant in the residual than in the tidal urine, and in some cases they were found in the former, while in the latter he did not succeed in finding a single bacillus. This fact had led to the suspicion in his mind that the bladder, in some cases, acted as a trap to catch and retain the bacilli, and he thought it even possible, under favorable circumstances, especially where there was blood and pus in the urine and where the bladder did not completely empty itself, that the bacilli might reproduce themselves there.

Recently, Dr. Bryson said, he had instituted some observations in order to learn the relative difference in the number of tubercle bacilli found in the residual and tidal urine. These experiments were carried out as follows: The patient would be requested to empty his bladder as completely as possible: a catheter, properly sterilized,

would then be introduced and the residual urine, which sometimes consisted of only a few drops, would be drawn off. The result of these experiments, taken as a whole, shows a remarkable difference between the number of bacilli found in the tidal and in the residual urine.

Dr. Bryson then exhibited a number of photomicrographs of slides, showing the number of bacilli present in the urine in five cases. In the first case the bacilli were rarely found in the tidal urine, while in the residual urine they were found in large clusters. In the second case they were never found in the tidal urine, and only a few in the residual. In the third case they were rarely seen in the tidal urine, but were found in large masses in the residual urine. In the fourth case there were none in the tidal urine, and quite numerous in the residual. In the fifth case they were very rare in the tidal urine, and very numerous in the residual.

Dr. EDWARD MARTIN said that his own results in searching for the tubercle bacilli in the urine were mostly negative, certainly in the early stages and sometimes even when there was profuse suppuration. They were only found in exceptional cases. Dr. Martin called attention to the fact that after the healthy bladder has emptied itself, no urine can be obtained for the time being by introducing the catheter, not even a drop. If the tubercle bacilli do multiply in the bladder, it must be due to the fact that in such a case the urine stagnates and acts as a good culture medium.

Dr. CHISMORE said that his experience with cases of tuberculosis of the genito-urinary tract had led him to be very wary of instrumental interference where it could possibly be avoided. The clinical symptoms will often give a strong suspicion of tuberculosis long before the bacilli can be identified. In one case where he was well satisfied that he was dealing with a tuberculosis, the bacilli were not found in the urine for a long time, in spite of frequent searches. The speaker said he regarded frequent micturition as probably the most reliable of the early symptoms of tuberculosis in the genito-urinary tract. In cases where the urethra and bladder had not been subjected to any manipulation, the micturition was painless, but the moment that even a slight traumatism was inflicted upon that urinary tract, then the micturition was not only frequent, but also painful, and the latter element was usually very persistent. Washing the bladder generally aggravates these cases.

Dr. Chismore said he had a very hopeful view of the ultimate results of tubercular affections of the genito-urinary tract. He saw no reason why such patients should not recover and enjoy good health in precisely the same way as patients with tuberculosis of the joints, or with other localized tubercular lesions do.

Dr. W. K. OTIS said he agreed with Drs. Martin and Chismore that the tubercle bacilli are not usually found in these cases; they are only found when there is an opening in some portion of the genito-urinary tract which allows the bacilli to escape into the urine. The urine may be full of pus and yet the bacilli are absent unless there is an open lesion.

DR. BRYSON, in closing the discussion, said that in certain cases the tubercle bacilli could not be expected to enter the urine at all, as, for instance, when they were confined to the prostate or cord. The speaker said he had thus far always succeeded in getting some urine with the catheter after the bladder had been voluntarily emptied, although sometimes only a few drops. Sometimes, by hypogastric pressure, he could cause a few drops to fall into the test-tube. His observation had shown him that very few tuberculous bladders are capable of completely emptying themselves. His chief object in presenting the paper was to offer a possible aid to the discovery of the tubercle bacilli in the urine.

The Relation of Oxaluria and Uric-Acid Excess to Genito-Urinary Inflammations and Disorders.—DR. BRANSFORD LEWIS of St. Louis read a paper on this subject.

After calling attention to the paucity of literature bearing on this subject, Dr. Lewis reported a number of cases coming under his observation. He gave the following as his conclusions:

1. Both oxalic and uric acid may appear in the urine either in a physiological or a pathological manner.
2. When pathological, they may exert certain injurious effects on the genito-urinary organs.
3. These effects may be either the inciting of disease where there has been previous health, or they may act by rendering more serious and resistant to ordinary methods of treatment other inflammations and disorders (gonorrheal, etc.) of those organs.
4. The uric-acid element is not always frankly evident as a causal or complicating factor in such cases.
5. And, when recognized, is neither more nor less easily controlled than where its disease manifestations occur in other organs of the body.
6. When either the oxalic- or uric-acid element is acting injuriously in the ways mentioned, systematic treatment (dietary, medicinal, and hygienic) is demanded, and may even take precedence over the local measures that are usually considered sufficient in such inflammations or disorders.

DR. J. WILLIAM WHITE said he had been in the habit of associating the uric- and oxalic-acid diatheses chiefly with nervous affections of the genito-urinary tract, such as impotence or pseudo-impotence, rather than with the infective inflammations of the urethra. The study made by Dr. Lewis in this connection was certainly an interesting one.

DR. BANGS said it had long been his habit to study these pathological changes in the urine and their relation to the urinary tract, and it appeared to him that when these constituents of the urine are present in excessive amounts they render the urethra more vulnerable and more susceptible to those conditions which we recognize as chronic. Dr. Lewis' paper shows the importance of frequent and careful analyses of the urine in such cases. Although he did not think it probable that constitutional treatment alone would effect a cure in many of these individuals, yet it might be the cue to the final

result and a powerful aid to the local treatment of disorders of the urinary tract.

THE PRESIDENT, DR. WATSON, said he had observed a number of cases of acute urethritis in persons who had never been exposed to gonorrheal infection, and whose urine contained excessive amounts of uric acid or urates; those cases, he said, yielded to systematic treatment more readily than an ordinary gonorrhea would have done. The speaker also referred to a case of intermittent hematuria in a man who suffers from persistent oxaluria, which can only be relieved by having him pass large quantities of urine. Excepting the hematuria, the man has no other symptoms of stone.

DR. BRYSON said he had often observed that the presence of uric- or oxalic-acid crystals in the urine aggravated inflammatory conditions of the bladder and urethra. He mentioned two cases of uric-acid diathesis associated with diabetes.

DR. J. WILLIAM WHITE said he had observed two cases of hematuria where the presence of the blood was inexplicable on any other theory than that it was due to the uric-acid diathesis. There were no subjective symptoms. The possible relationship between oxaluria and sexual impotence was first brought to his attention many years ago by the late Dr. Agnew. As regards the treatment of these cases of uric- or oxalic-acid excess, the speaker said he had lately given up salicylic acid in favor of a mixture composed of caffeine, phenacetin, and salol.

DR. RAMON GUIERAS of New York reported the history of a case of oxaluria which had recently come under his observation.

DR. CHISHORE said that fame awaits the man who can cure the gonorrhea of a patient whose urine contains an abundance of oxalic-acid crystals.

DR. WATSON referred to the persistence of phosphaturia, and narrated the history of a patient with this affection who has traveled all over the world in search of a cure.

DR. BRYSON said he had seen phosphaturia disappear under the administration of small, repeated doses of calomel.

DR. LEWIS, in closing the discussion, said he had observed one case of persistent hematuria which depended on the presence of oxalate of lime crystals in the urine. The speaker said he agreed with Dr. Bangs that systemic treatment alone is not sufficient; local treatment must often be instituted. Dr. Lewis said he had observed numerous cases of gouty urethritis in patients who had never been exposed to urethral infection. As regards diet, there is a marked difference to be observed in the treatment of the oxalic and the uric-acid diathesis; in the former, a meat diet with avoidance of vegetables is the proper thing, whereas if there is uric-acid excess, just the opposite diet is indicated. As regards therapeutic measures, the speaker said he had often obtained good results from the salicylates, preferably in the form of salophen, which does not disturb the stomach as much as salol.

DR. WILLIAM K. OTIS of New York exhibited an instrument for photographing the interior of the living urinary bladder.

The following officers were elected for the ensuing year:

President, Dr. J. William White of Philadelphia.

Vice-President, Dr. James Bell of Montreal.

Secretary, Dr. William K. Otis of New York.

It was decided to hold the next meeting of the Association at Sing Sing, N. Y., in June, 1898.

Necrology.

STOUKOWENKOFF.—Professor Stoukowenkoff died on March 14th last as he was inaugurating the Physico-Medical Society of Kiew which he has just founded. He was seized in the midst of his address and expired before he could be removed. His work, familiar here, has been on the treatment of syphilis by injections of the benzoate of mercury.

J. C. J.

FEULARD.—Among the unfortunate victims of the recent disastrous fire in the Charity Bazaar in Paris there is none whose loss is more deeply to be deplored than that of Dr. Henri Feulard—one of the most promising of the younger school of dermatologists in France. Although comparatively a young man, he had made for himself a distinguished reputation as an earnest and enthusiastic worker in this special field. The writer first met him some ten years ago in Paris and was charmed, as was every one with whom he came in contact, with his amiability, his scientific ardor, and his many agreeable personal qualities. He was then on the threshold of a career which, though brief, he has made brilliant by his work as a physician, a writer, as one of the editors of the *Annales de Dermatologie et de Syphilographie*, and of the *Atlas du Musée du Hôpital Saint Louis*, and his intelligent activity in other directions.

The details we have received of the circumstances of his death, though meager, show that he died a martyr to his heroism and his devotion to duty. He had escaped in safety with his wife, but plunged again into the fiery furnace to rescue his daughter. He was unsuccessful and both perished. It is a noteworthy fact, according to the *Journal de Médecine de Paris*, that of the 400 men estimated to be in the burning building, all but three escaped with their lives. Of the three who sacrificed themselves in their attempts to rescue others two were doctors.

P. A. M.

Items.

FERRATIN.—This organic iron compound, identical with the ferruginous extract from all food, animal and vegetable, and stored in the liver and other organs, "as reserve iron for blood formation" (Schmiedeberg), is to become official in the new edition of the Russian Pharmacopœia on the recommendation of the committee now working on the revision. Ferratin is recommended as a prompt tonic for convalescents, especially those recovering from the shock of operations.

LEPRA CONFERENCE.—The congress will assemble at Berlin in October, 1897, under the auspices of a committee consisting of Drs. Ehlers, Hansen, Koch, and Lassar. A most interesting program has been prepared in which the subject will be treated from all points of view by leprologists of international reputation. Among the well-known names, each writing in his own field, are Koch, Virchow, Unna, Besnier, Hutchinson, Campana, Hansen. The question will be presented in its geographical aspects by delegates from all civilized countries. Dr. J. C. White represents the United States.

Pityriasis Rosea. TANDLER (*Archiv. f. Derm. u. Syph.*, Bd. xxxvii, Hefte. 1 and 2).

Twenty-seven cases were studied in order to give the conclusions embodied in the article. As a result, Tandler concludes that Kaposi is wrong in his assertion that the disease is identical with what he terms herpes tonsurans maculosus. No fungi could be cultivated from the lesions except a few staphylococci, nor could the tricophyton be demonstrated in any of the sections prepared from the diseased tissues. The only changes found were in the corium, and these were of a purely inflammatory nature, offering no basis for the assertion that the nature of the affection is mycotic.

NOTICE.

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AMERICAN DERMATOLOGICAL ASSOCIATION.

TWENTY-FIRST ANNUAL MEETING, HELD IN WASHINGTON, D. C.,
MAY 4, 5, AND 6, 1897.

FIRST DAY, TUESDAY, MAY 4TH.

ADDRESS BY THE PRESIDENT, DR. JAMES C. WHITE OF BOSTON.

GENTLEMEN:—It may be claimed as a proper justification for my addressing you a second time from the president's chair that it is good custom when a child comes of age that one of the seniors, who was present at the birth, should preside at the celebration and say some words fitting for the occasion. So I, who had the great honor of serving as the chief official sponsor at the foundation of this Society, may not inaptly venture to speak for it again when it has attained its majority.

This is the twenty-first annual meeting of the American Dermatological Association, the oldest national association of its kind in the world. Twenty years ago it was my high privilege to welcome the charter members at their first gathering—twenty-nine in number, of whom but eleven are still with us—and to present the sketch of a plan for the future conduct of the Society. The purposes and scope of such an association therein suggested, and subsequently adopted, have been, in the main, faithfully followed, and we may well pause at this turning-point in its career and, looking backward, inquire what has been accomplished of the bright promises of its infancy. Such a retrospect may best be brief, however, for several

of my predecessors in this Chair have, from time to time, reviewed what has been done for dermatology by this Society.

In that first address I expressed the hope that the dermatologists of this country, who lived widely apart, and had been working without meeting one another, some of them for twenty years, would find great advantage in forming a mutual personal acquaintanceship, and comparing and reconciling their individual opinions, often previously of unfortunate variance. Certainly we may congratulate ourselves that this most desirable aim has been completely fulfilled; that it is a sincere delight to us to meet one another at these yearly gatherings; that our respect and esteem for each other has been constantly strengthening during all these years, and that we express and criticize our individual observations and beliefs with the utmost frankness without jarring in any measure our bonds of good-fellowship; and this was not always so, as some of us remember.

Another object we hoped to attain was the elevation of our specialty to its proper rank among the departments of medicine, and a great advance has been accomplished in this direction.¹ Some eighty medical schools in this country are now teaching dermatology especially, where scarcely more than ten then gave instruction in it. In some of them its character must still, no doubt, be capable of improvement, but in some of them it rivals the best schools of Europe in the quality of the teachers, the size of their clinics, and its standing as a requisite part of medical education. The practice and writings of American dermatologists to-day, it may be claimed without boasting, are on a plane as high as those of their European colleagues. The profession at large, too, recognizes more generally than formerly the importance of the independent position of the dermatologist, although we all still meet now and then, no doubt, the practitioner who claims absolute ownership of his patients, and denounces all specialists as needless or worse. The lamentable ignorance of such physicians, too often, concerning cutaneous pathology deserves open exposure. Strange to say, the country doctor more generally and modestly appreciates the limitations of the individual intellect, and rarely claims such omniscience. In one other respect the relation between the exclusively dermatological practitioner and the family physician are not yet upon a wholly satisfactory basis, even when the former is called in consultation, or is asked to suggest a plan of treatment by letters after a single visit from the patient. It is absolutely necessary, if any important results are to follow such advice, that the case should remain under the immediate observation of the specialist in the majority of affections, for thus only will the directions, however carefully expressed, be carried out with that particularity so essential to success, and in certain diseases the ever-changing nature of the process demands as frequent a modification of the original advice under trained oversight. It is my custom to inform students that the second visit is often of more importance to the patient than the first; that the errors in treatment resulting from failure to carry out the instructions given may be corrected. I have known a physi-

¹ Dr. Morrow's address to this Society in 1890.

cian to continue the use of an ointment advised for three days in a case of scabies for a whole year without interruption, and the common remark then to be made: "Oh, it does no good to consult a specialist." Are we not all continually meeting with such experience? Patients have yet to learn their independent rights in relation to special professional practice.

Another highly important purpose of the Society has been the gathering of data concerning the prevalence and character of diseases of the skin on the North American Continent. Here, as in no other country of equal civilization, exist the most extreme variation in the physical conditions of life and the greatest diversity in the ethnical features of its population. Here new types or modifications of cutaneous affections might well be looked for. The work accomplished by our standing committee on statistics in this direction cannot be overestimated. Under the careful and persistent efforts of its accomplished chairman, Professor Hyde, there has been collected an enormous material bearing upon the prevalence of diseases of the skin under the observation of skilled dermatologists, such as exist in no other part of the world. By its agency we have discovered the previously unknown amount and locality on this continent of leprosy, for example, so essential to its necessary control.

Much has been done by the Association also to advance our knowledge concerning the character of skin diseases among us. During these twenty years 327 papers, containing the valuable results of the observations of its members, have been presented to this Society, and have been thoroughly discussed at the annual meetings. These studies and comparisons of individual opinions, so freely expressed, have been of great benefit to the progress of dermatology.

And some mention may well be made here of other and larger contributions to the literature of our specialty by members of this Association during this period. At the time of our foundation but one or two books on general dermatology written by them were in existence. Since then four general treatises and six or more important works on special subjects have been published by them, not to mention several extensive collaborative publications, to which they have made noteworthy contributions. Several excellent atlases of illustrations have also been issued by them. Nor should I neglect to give due credit to that praiseworthy periodical, the JOURNAL OF CUTANEOUS DISEASES, which has been conducted in so self-sacrificing spirit by successive editors of our number, and to which we have been greatly indebted, both as a Society and as individuals. It is to be regretted that a journal devoted to the interests of dermatology alone should not meet with sufficient support in this great country, and that it must needs be associated with another specialty, with which it has no natural affiliation.

One other desideratum the Association has had in view from the first, *viz.*, the adoption of some system of classification and nomenclature for purposes of registration and mutual understanding. This most desirable object has received the serious consideration of sev-

eral able committees, but by no means such attention on the part of the Society as it deserves. The construction of an acceptable classification on any stable foundation in these days of ever-shifting pathology may, indeed, be of Utopian prospect, but there is no excuse for our neglect of the question of a system of nomenclature, however artificial or arbitrary. A truly Babelian confusion now characterizes our returns.

Nor should mention be omitted here of the annual publication of the list of writings of members of the Association. Its length and great diversity of subjects bear witness to the activity of our colleagues, and in connection with the exhaustive reports of Dr. Duhring in his two presidential addresses, and the carefully prepared work of Dr. Jackson, forms an invaluable bibliography of modern dermatology.

Such were the chief aims of the Association as recognized at its foundation, and they have been, in the main, satisfactorily adhered to and fulfilled. They have received the support of the distinguished members who have graced this chair—sixteen in number—and other valuable suggestions have been made by them from time to time, with regard to the conduct of the Society, which have deserved serious consideration. Some of them have been adopted to our great advantage. To one of them, first proposed by Dr. Hyde, I again ask your attention, as I regard it as a matter of material importance to ourselves, and of fairness to the dermatologists of the United States who are not connected with this Association. We have at present forty members. Now, I would not lower the high standard of qualification we have hitherto maintained as essential to admission to the Society in the least, but it may well be questioned if there be not a considerable number of physicians who devote themselves exclusively to the study and practice of our specialty, whose position as teachers and whose published writings show them to be fit candidates for this Association. I met such men at the International Congress of Dermatologists in London last summer. It is possible that in this vast country of ours there are many more of them than we have knowledge of. Under our present system, proposals for membership come mostly from those of us who are especially interested in some person through friendship or other affiliation. It is no one's business to look over the field and see to it that some most deserving dermatologist, not thus favorably circumstanced, is not neglected on our part, to our detriment and his own. He would not be likely to present his own claims. It would be well, in my judgment, if a standing committee were established, whose duty it should be to keep a record of all prominent physicians in our specialty on this continent, of their home-work and standing, of their published writings, of their time passed in practice, and of other facts bearing upon their fitness for fellowship with us, and to present them to us at proper time for consideration. Such a committee, representing various parts of our country, would not be swayed unfairly by personal feeling or local influences, and their recommendations would carry great weight. At present the council, to which

all chance nominations are referred, is a constantly changing body, and with little time at our busy meetings to give them proper investigation. All nominations for membership should be referred to such a committee one year before action could be taken upon their report by the Society. Such a plan, if adopted, would require an alteration of the Constitution.

There was another subject referred to at some length in the first presidential address, which I regarded as of preëminent importance to the welfare of American dermatology, and which occupies to-day, I regret to say, largely the same deplorable position as then. I refer to the establishment of hospitals or wards for the care of patients with skin diseases under the exclusive charge of dermatologists. I can hardly state the necessity of such more strongly than at that time, but must repeat that, under existing conditions, instruction in dermatology in this country is most seriously handicapped, and that its medical schools in this particular must continue to occupy a far inferior position to those of Europe, and our students must still be forced abroad to acquire in sufficiency this important part of their professional education. If anyone think this statement overdrawn, let him look about him for any approach to the opportunities afforded for the study of cutaneous diseases by the St. Louis Hospital in Paris or others in smaller capitals which might be mentioned.

There remains one other matter of general interest to the Association, and within our own control, which I cannot refrain from speaking of, though not in words of praise, *viz.*, our published transactions. They have been far from creditable to us. The twenty volumes are not uniform in appearance, they contain serious errors arising from improper revision, misrepresentations of statements, trivial summaries of important communications, and disjointed and meager reports of discussions. They are wholly unworthy of this Association, in my opinion, and their further publication in any such shape had better be discontinued. It would be impossible to publish an annual volume containing all communications, discussions, and reports in full in proper form without largely increasing the yearly assessment upon members, doubling the present rate, possibly; and unless the Society will agree to this method of raising the necessary fund, we had better content ourselves with the simple publication of our proceedings in some medical journal by the secretary. The alternative should be the foundation of a new series of our transactions in complete and appropriate shape under the management of a standing committee on publication. Its success might be assured by the establishment of a permanent fund for this purpose, raised by voluntary contribution, in addition to some increase of the annual assessment. May I ask the serious attention of the Council, under whose control all publication of papers and proceedings lies, to this important subject.

And now beyond these immediate interests connected with our own career may we not appropriately at this notable era look backward briefly at the changes which have marked the progress in our specialty during these twenty years? How much more do we know

than when first we met together? We should know much more, because the means of learning have been immensely enlarged. Formerly we got our knowledge from a few books, and fewer teachers, and the observation of patients too often through glasses selected by the former. We have grown to be independent of such methods and all dicta. Then the teachers have become broader and more progressive, and the greatest of them have learned the great lesson that they can never stop going to school themselves, and that this school is limited by no racial or geographical boundaries. They meet their own immediate colleagues frequently in local dermatological clubs and societies, once a year their national co-workers in wider fields, and every four years in an international congress their fellows from all the countries of the world. They learn in this way how small a fraction of knowledge is any one man's portion. In such a congress there is no seat for the dictator in medicine, and this is, perhaps, the most important object of its being. Every teacher should return home from such a gathering a more modest man, a humbler student. The teacher who is contented with repeating the doctrines expressed from his chair, or in his book, twenty or even ten years ago, and ignores the work of other and later observers of every nation, cannot retain the title of great. That is the highest school of dermatology which is the most liberal and cosmopolitan in its views and sources of inspiration, and any national school which in these days remains unreasonably subservient to the dicta of any one man, dead or living, deserves no longer an international following. And besides these public schools of learning, these associations and congresses, the great levelling places of personal equations, there have arisen the laboratories, where the all-important foundations of scientific medicine are being laid so quietly at last beneath our old superficial structures, based hitherto almost wholly on clinical observation and arbitrary deduction. It is not only an exact pathology which they are surely establishing, but a reasonable therapy as well, and any moment a discovery of a nature to revolutionize our control of the gravest diseases which afflict mankind may be flashed from their portals. How far-reaching have been the results of the investigations made within them in our epoch upon our specialty:—The demonstration of the bacillary nature and the unity of all forms of cutaneous tuberculosis, formerly regarded as distinct affections, and of their intimate clinical relations with pulmonary forms of the disease; the discovery of the cause of leprosy, and the vast importance of this explanation of its real nature upon all its etiological relations and its future extinction. The recognition of the germ of syphilis stands next in succession, let us hope, although this confirmation of our foreknowledge will have little effect, except possibly in the direction of therapeutics. Studies in staphylococci have practically abolished one of our our best known lesions, the pustule, as a primary or integral expression of the inflammatory process in cutaneous pathology, and the rôle of parasitism as the essential factor in the etiology of skin affections has been enormously magnified. Modern methods of investigation have

also greatly extended our knowledge of the multiplicity of plant forms in our longer known fungus diseases. The practical outcome of all these scientific studies is becoming immediately apparent, so that the bacteriological, as well as the histological laboratory, has become as important a part of the equipment of a department of dermatology as the clinical ward or out-patient service. They should be intimately associated in every school of medicine.

A great advance has been made, too, in a closer discrimination in the gross features of disease, so that conditions formerly considered a unity, have been separated from one another, and given an independent position on our list. Among the more notable examples of these newly constructed or newly recognized affections, are:

Acantholysis, or epidermolysis bullosa; acanthosis nigricans; actinomycosis, in its more generalized cutaneous manifestations; angioma serpiginosum; dermatitis exfoliativa, in forms not previously comprised in Hebra's pityriasis rubra; dermatitis herpetiformis of Duhring; dermatitis gangrenosa; dermatitis papillaris capillitii; dermatitis medicamentosa and venenata, of which our knowledge has been greatly extended; erythrasma; erythème induré des scrofuleux; granuloma fungoides; hydrocystoma of Robinson; hydroa vacciniforme; keratoma: multiple benign cystic epithelioma; myoma; myxedema; psorospermiosis of French, or keratosis follicularis of American writers; pemphigus vegetans; pityriasis rubra pilaris; porokeratosis; syringomyelia; urticaria pigmentosa; xanthoma diabeticorum.

A comparison of the earliest statistical returns of the Association with those of the last few years will show a great addition to our list of real or pseudo-titles. On our first form for statistical returns, issued in 1878, there were one hundred titles. On the blank now in use there are one hundred and thirty-six titles, and in the supplementary table printed in our last published returns, seventy-six additional titles are given, although these are largely synonyms. The selection of the term prurigo as the first topic for open discussion in the late meeting of the International Congress of Dermatology, and the diversity of opinions there presented, demonstrate, as an example, on how unstable and unsatisfactory a basis our nosological system rests.

The introduction of absolutely new physical influences among mankind is also creating hitherto unknown tissue changes in the skin of those exposed to them. The Roentgen-rays, for instance, have shown their capability of producing a powerful destructive action upon the hair and nails, a dermatitis of peculiar type, and a deep necrosis of the cutaneous structures, followed by prolonged and inexplicable impairment of the process of repair. Let us hope that they may be possessed of as powerful curative possibilities to be isolated and controlled. Again, the introduction of a strange plant from the remote deserts of China to our household flora gives rise to a novel type of cutaneous inflammation, and the invention and use of new remedies is continually starting up fresh forms of dermatitis medicamentosa to be recognized.

And with our great advance in knowledge of the nature of diseases of the skin, thus briefly and imperfectly sketched, what gain have we made in means of cure? Very little as yet, it must be said, but we are beginning to discover as the result of etiological research the basis of a rational system of cutaneous therapeutics. Our small list of specifics should be greatly lengthened when we are no longer obliged to search for them along a line of purely empirical experimentation. Let us hope that the time is soon coming when we shall not have our efforts in this direction characterized by a trial of every new chemical product which the ingenuity of the synthetical chemist can devise, and heralded as of prodigious potentiality against this and that affection by the professional trumpeter of the manufacturing firm, but rather avail ourselves of every hint emanating from those engaged in studying the natural history of the germs which cause disease, and the action of reagents upon their vitality under culture. I see no limit to the hopes which may be ultimately realized from such research. The accomplishment of immunity by inoculation of the products of specific germs or modified serum against such affections as leprosy, tuberculosis, and syphilis is a perfectly reasonable expectation. The fact which Jenner determined by accident and shrewd observation has been converted into a scientific principle by Pasteur and Koch, and the imagination can hardly be too daring in forecasting its possible benefits in preventive and curative medicine. Some of you will live long enough, let us trust, to see every child immunized by inoculation against all infective diseases as regularly as now against variola.

So much for the past of our Association and for the progress of dermatology during its existence. And now a few words more as to its future. Can we in any way make it more useful than it has been? I see but little room for improvement in the objects and methods we have so uniformly and successfully adhered to thus far. They are those which have been followed mainly by all the many similar associations which have been founded since our own. In one or two directions, however, a change might be made with advantage. I think an effort should be made, as already stated, to make our membership broader and more national, without lowering the high standard of requirement hitherto observed; and secondly, that we should introduce into the conduct of our meetings a feature which gave to the late International Congress at London so distinguished a success. There, in addition to the usual program of papers without number, which were hastily discussed by a few of the several hundred dermatologists and syphilographers in attendance from all parts of the world, who all returned home probably with their individual views on every subject considered unchanged or more fixed than before, was arranged a great exhibition of all the means of illustrating the pathology and pedagogy of diseases of the skin. Portraits, photographs and models, microscopic sections and bacteriological cultures, in enormous numbers, were brought together from near and far, and constituted a marvellous object lesson in dermatology. The work of our most distinguished colleagues, with which we were

previously familiar only by description, was there before us for examination and comparison. There was collected an hour or more before each session a wonderful series of cases, examples arranged in groups of the rarest and most interesting affections of the skin. Hundreds of such patients gathered from all parts of Great Britain and its various colonies were thus shown, many of them of extraordinary character. In their presence the most renowned masters and diagnosticians should have felt helpless. Surely every one there, the most accomplished and experienced, must have felt how much remains to be learned in our department of medicine, and how vast the privileges of our English confrères with such opportunities for observation. Now, although we may not hope to rival such an unprecedented exhibition, we can certainly bring together every year much material of a similar character, which could not fail to add greatly to the interest and value of our meetings. We are all constantly meeting with cases of extraordinary character, as the experience of our local dermatological clubs proves, which might be discussed on this broader meeting ground with undoubted advantage to all of us, and occasionally to some one of us is vouchsafed a unique example of dermatosis, which might never be known to the rest of us, unless presented in this way. We have all of us, no doubt, upon our existing lists cases such as we know our fellow members would like to see here. The Council has thought it advisable to make the attempt this year to introduce such a clinical feature upon our program, although Washington is over far from the great centers of professional activity to warrant any expectation of a full success at this Congress. Indeed, it may be doubted if these triennial meetings conduce to the best interests of our society. If the Association favor the future development of such a clinical exhibition, it may well determine the selection hereafter of the place of meeting in our large cities, and a local committee should be annually appointed to to have charge of it. I do not see how it could fail of being a most attractive and valuable addition to our program.

Then, too, we have accomplished microscopists and bacteriologists among our members, and the results of their valuable work would be better appreciated by us if it were submitted to our direct inspection. They certainly deserve the assignment of a fixed opportunity for such a demonstration upon our card. Some of our papers could be presented in much more complete form, if illustrated by such a supplementary display.

And we should have our annual gallery exhibition, to which every member should contribute all additions of his personal collection during the year of drawings, photographs, paintings, and models, representing any case of unusual interest. To the question of the permanent adoption of all these additional measures for making our meetings more attractive and instructive, I beg your serious attention. Let us not neglect any means of keeping our society in the highest rank of kindred associations.

Death has dealt lightly with us during our first twenty years, but another double decennium can carry to its end but few of our orig-

inal members. Let us hope that our successors will transmit the Association to theirs with purposes as high and record as honorable as those we commemorate to-day.

A Contribution to the Study of Bleeding Stigmata.¹—DR. J. N. HYDE of Chicago reported the case of an adult male subject who suffered from hemorrhages from the surface of the skin apparently spontaneous in origin. Some of these bleedings had lasted for six months at a time. Eventually there was a shortage of fifty-five per cent. of hemoglobin and nearly sixty-five per cent. of erythrocytes. The author reviewed the literature collected under the titles, bleeding or bloody stigmata, bloody sweat, hematidrosis, Hautblutungen, hysterical stigmata, and ecstasy; concluding as follows: "It is clear that at times spontaneous hemorrhage occurs from one or many points of the skin simultaneously or successively, either as a result of morbid changes in the circulating fluid itself, or as a consequence of disease of other organs, in particular the nervous centers, the spleen, the liver, and the kidneys. One may look with tolerable confidence in most of these cases, first, for an oozing of blood from many points at one time rather than from a single point at one time; second, for an unquestioned evidence of a morbid state elsewhere than in the skin. Suspicion attaches to a second group of cases by reason of the fact that the effusion of blood from the surface of the integument seems to have been shared with spontaneous gangrene in the devices of the impostor. In analyzing the phenomena exhibited in this class of subjects the possibility is to be set aside, first, of the staining of the physiological secretions by foreign matters or by micro-organisms existing upon the surface; second, of the substitution for human blood of that of one of the lower animals. When human blood is actually effused from the skin of a subject who has been instrumental in producing the result, not only are all the sites of the hemorrhage within easy accessibility of the hands of the patient, but there are mental and nervous changes which require recognition. The mental states of this class of subjects often defy analysis; among the nervous symptoms may be named disorders of the special senses, particularly of sight, hearing, olfaction, and gustation, and the occurrence of anesthesia and of hyperesthesia."

Four Cases of Hysterical Dermatoneurosis.—By DR. A. VAN HARLINGEN of Philadelphia.

These two papers were discussed together.

DR. L. A. DUHRING: I have been interested in following the papers just read by Drs. Hyde and Van Harlingen. It occurred to me, in listening to the history of Dr. Hyde's case, that instances of that kind are extremely rare. I am familiar, as we all are, with cases in literature of a similar or identical character, but very few of them have been observed in this country. I have never seen a case similar to the one described by Dr. Hyde.

Concerning Dr. Van Harlingen's paper, I would take exception to its title, which is altogether inadequate. I always regret to see

¹ Will be published.

a title possess only a vague idea of the sentiment or purport of the paper. The term, hysterical dermatoneurosis, conveys no information beyond its general etiology. I trust he will see fit to add something to the title which will give an idea of the lesions. I think if he will attempt to classify the cases it will be advantageous. The literature is vague and complicated, due largely to the fact that writers have not taken the trouble to be definite in expressing their observations. I have seen some of these cases such as Dr. Van Harlingen has described, and there is one point, partly brought out by him, to which I would like to refer. That is, that the writers upon the subject in the past—especially writers upon feigned diseases of the skin, which seem so closely like these as to deceive sometimes even experts—have not been in the habit of insisting upon peculiar forms of lesions as characteristic of artificial manifestations. Almost every text-book published during the last thirty or forty years has held that the so-called hysterical diseases are generally factitious. My experience is similar to that of Dr. Van Harlingen, namely, that many of the hysterical excoriated diseases are more or less angular in outline, so that the manifestation of angularity, like that produced by artificial means—as by a finger-nail or pin—is not at all in support of the view that the disease is artificial. I have seen hysterical excoriations that have simulated artificial eruptions, which I have proved subsequently were, beyond doubt, hysterical or nervous in origin. The fact that the lesions have an appearance of artificiality is no proof of their being produced by artificial means. I think there is no doubt that many cases that have been set down in the past twenty-five or fifty years as being produced artificially, are really distinctly neurotic. I have seen few artificial or feigned eruptions during the past thirty years. I have seen many more of the other kind, namely, hysterical diseases.

The matter is one of considerable importance to us, because it bears distinctly upon the field of general pathology, and especially upon the condition of the nervous system as a whole, and its connection with the cutaneous surface. I am convinced that the relation of the nervous system, as a whole, to the skin, is one of very great importance.

DR. PRINCE A. MORROW : I was much interested in the paper of Dr. Hyde. It is very rare that the phenomena of bleeding stigmata can, as in this case, be ascribed to a material agency as an exciting cause. As is well-known, cases of this character are not uncommon, and were formerly attributed to supernatural power. Occurring among the mystics and religious enthusiasts of the fifteenth and sixteenth centuries they were regarded as of miraculous origin. By others they were ascribed to demoniac or satanic influence. The literature of demonology abounds in such cases. At the present time, these phenomena admit of a more rational and scientific interpretation. They almost always occur in neurotic or hysterical women and are closely allied to the phenomena of demographism. We can readily conceive that the vasomotor excitability may be so pronounced as to

permit the passage of the corpuscular elements as well as the serum of the blood through the dilated vessels.

The cases of feigned eruption described by Dr. Van Harlingen are also of great interest from the standpoint of differential diagnosis. According to my observation such cases are by no means uncommon, and I cannot concur with Dr. Duhring in his belief that they are rarely of factitious origin. The patients who present these symptoms are often gifted with remarkable cunning as well as duplicity, and in practising the deception they take every means to conceal its artificial origin. The propriety of the term "hysterical" as applied to these cases cannot in the present state of our knowledge be contested. It is a very comprehensive and elastic term and covers our ignorance of the actual condition.

DR. JOSEPH GRINDON: One point which struck me was that brought forward by Dr. Van Harlingen, the very remarkable fact that lesions occurring under very different ethnological circumstances and in different parts of the world, should present such great similarity as we find in many of these cases of hysterical or "feigned" eruption, often wrongly so called. I am reminded of many cases which have been reported, in which recurrence and the formation of crusts similar to those produced by chemical cauterants are mentioned.

The latter character was noted in the case of dermatitis vesiculosa neurotraumatica of the forearm which Dr. Duhring reported five years ago, and in Kaposi's cases of zoster gangrenosus recidivus atypicus hystericus.

The possibility of self-infliction of these lesions is suggested, and yet one can hardly believe that such observers as those just mentioned could be deceived on such a point, so that I suppose we will have to reconsider some of our views and to believe that these things are self-inflicted, if at all, in a very different sense, being the result of what we must call a trophoneurosis, arising perhaps from autosuggestion.

DR. BRONSON: It is a well-known fact that strong impressions on the sensorium, especially those of an emotional character, are capable of effecting changes in the skin. The phenomena of blushing, erection of the hair, cold hands and feet, and the like are some of the most common of these effects. A more striking instance is the erythematous eruption observed in sensitive people, sometimes, especially young women, spreading not only over the face, but over upper portions of the trunk, often of a spotty appearance, and persisting for a considerable time, commonly known as "The Doctor's Rash," because of its occasional occurrence in nervous patients when disrobing for medical examination. Sudden graying of the hair under stress of emotional excitement is well authenticated. Under similar conditions irritable trophic changes in the skin have been noted. In some cases the skin affection is apparently the effect of hypnotic influence or autosuggestion, as, for example, in the cases of stigmatism. The well-known case of Louise Lateau is an authentic instance. It was observed closely, and carefully

reported by Devergie. There appeared at stated intervals in the hands, feet and side, at points corresponding to the so-called "stigmata of the Lord," first, spots of erythema, which were followed by ecchymosis and bleeding.

In some cases the psychic influence is less apparent, as in the case of Dr. Hyde. Kaposi of Vienna had once mentioned a case in which sudden hemorrhages would occur from the backs of the hands in a physician, who it was stated had formerly assumed the rôle of Jesus in the Passion Plays at Oberammergau. A little jet of blood would spurt up apparently from one of the follicles of the hand without apparent cause. It was not an infrequent occurrence. When an excoriation, ulceration, or inflammation of the skin occurs that seems out of the usual cause, and cannot otherwise be accounted for, it is easy to call it an artificial or feigned eruption. The so-called "neurotic excoriations," described by Wilson, have by many been recorded as "feigned." But such lesions may be in a degree artificial without any deceit on the part of the patient. It is quite possible that in certain hyperesthetic, or highly neurotic subjects a very slight traumatism, or friction, even, of which the patient is hardly conscious, may be followed by an exaggerated effort that is quite out of proportion to the artificial cause. In the cases which have been referred to mention was made of the angular outline of the lesions. Such an outline could hardly be accounted for as due solely to any interior influences, but would pretty clearly imply an exterior and artificial cause.

DR. J. A. FORDYCE spoke of cases of purpura in which the plasmodium malariae had been found. A physician in general practice had called his attention to the frequent occurrence of malarial organism in the blood of patients with purpura. He had observed the rapid curative action of quinin in several cases in his own practice.

DR. D. W. MONTGOMERY: As Dr. Duhring says, I think these diseases should be separated from one another more definitely.

The case Dr. Bronson spoke of is of interest to me, because of having had some experience with these red blotches, and I think it will be found that they occur most frequently in the eyelids. A friend of mine, Dr. Hoisholt of Stockton, California, told me a short time ago that he had often noticed sudden redness and swelling of the skin of the lids of one or other eye among the insane, and he attributed it to a reflex from the stomach. Some months ago a young man was sent to me suffering every three or four days from redness, swelling, and itching of the skin of the lids of one or other eye. The boy was rather stupid, took very little exercise, had a large appetite, and I ascribed his trouble to reflex irritation from the stomach or intestines, and treated him accordingly, but with no success. He afterwards went to another doctor, who also evidently referred his trouble to an irritation in the alimentary canal, and persistently washed out his stomach till finally the hyperemia ceased to appear.

In another instance the patient suffered from a circular, itchy erythema of the neck, which I treated in vain until I noticed the

erythema almost always appeared on Saturday night or Sunday morning. On questioning him it transpired that, as he was a good churchman, he ate omelet every Friday evening for dinner. The omelet was interdicted, and the erythema ceased to appear. It returned again once after eating a meal of dried codfish in Lent.

In regard to gangrenous patches caused by hysteria, we had a very interesting case of this nature shown before the State Medical Society, by Dr. Rixford, a few days before I left San Francisco. The patient, a young girl, had several patches of gangrene on the right upper extremity. There was analgesia of the affected arm, and slight loss of pharyngeal reflex. Leprosy and syringomyelia were excluded, and after a most careful consideration of the case the possibility of the gangrene being artificially produced seemed to be highly improbable.

DR. J. N. HYDE: Mr. Chairman, I was interested in Dr. Van Harlingen's paper, and desire to add that we should lose a valuable means of recognizing the artificial character of certain eruptions if we failed to estimate the angularity of outline so conspicuous in some skins. With reference to what Dr. Duhring has said, I think we do see unquestioned cases of "feigned eruption." How common it is to see a man who has been scratching himself from knee to foot and presents a complicated clinical picture, who is yet unconscious that he has himself produced a large portion of his trouble.

With reference to the suggestions of Dr. Gilchrist, he probably did not notice the fact that the patient whose case was described was the subject of a single hemorrhage in a grave condition. The successive hemorrhages were historical.

Two Cases of Linear Nævus, with Remarks on its Nature and Nomenclature.¹—By DR. PRINCE A. MORROW.

The reader first referred to the indefinite place which this affection occupies in the chronological category, and the meager information contained in our text-books in dermatology respecting its nature and pathology. The number and variety of the titles under which it had been described by different writers was an evidence of the looseness of the terminology and calculated to create confusion. The cases which formed the subject of the paper were examples of a peculiar dystrophy of the skin, the more typical and distinctive characters of which were thus summarized:

1. Its linear disposition in the form of distinct streaks or lines. In some cases the bands are parallel, in others radiating with a branched or dendritic arrangement. The eruption in certain cases seems to follow the course of definite nerve tracts or is superimposed on the lines of Voigt; in others no such correspondence can be traced.

2. Its unilateral character.

3. Its papillary or verrucose aspect. In exceptional cases the lesions appear in the form of flattened lichenoid or scaly papules suggesting in aspect an eczema or psoriasis.

- 4 The affection is of congenital origin. It usually appears within

¹ Will be published.

the first few months after birth, but its manifestation may be delayed until the period of adolescence or later.

5. Sensory disturbances are usually a marked feature, especially under the influence of external irritation; they may, however, be absent.

6. The affection may increase in extent, remain stationary, undergo spontaneous involution, or exceptionally, a malignant transformation.

Two cases of this affection were described and colored illustrations shown.

CASE I. was a healthy looking young man, 29 years of age. The eruption first appeared 12 years ago in the form of a scaly patch in the middle of the left palm which gradually spread upward and downward until it now appears as a ribbon-like band extending from the middle finger along its palmar aspect and over the middle of the palm to the annular ligament. Above this point it broadens out into two parallel streaks and extends upward along the inner anterior aspect of the forearm and terminates in scattered lesions just below the flexure of the elbow. The eruption is made up of minute reddish papules, closely aggregated, the surface is deeply pigmented, slightly elevated, rough and harsh to the touch and covered with whitish extremely adherent epidermal scales. The lesions seem to correspond to the follicular structures of the skin.

CASE II. was that of a young married woman of nervous temperament, aged 25. The first appearance of the eruption was noticed seven years previous in the shape of a reddish streak like a scratch mark on the back of the neck which gradually extended up into the scalp and down the side of the neck. Two years later there appeared two or three parallel streaks extending down between the shoulders to the middle of the back immediately to the left of the spine.

On the back and sides of the neck the eruption appears in the form of streaks which are prolonged upward in the hairy scalp and branch over the side of the neck back of the left ear and below to the cheek. By this branched arrangement islets of healthy skin are circumscribed, giving to the eruption as a whole a roughly reticulated appearance.

The lesions consist of small reddish scaly papules, closely pressed together, but separated by minute furrows which correspond to the lines of motion of the skin.

An analysis of a large number of cases of *nævi* shows that no two are exactly alike, while hyperplasia of the epidermis constitutes a dominant trait. They differ in their histological structure accordingly as the vessels, the papillary body, or the glandular elements of the skin are chiefly involved. They differ also in their date of development, and in their evolutionary mode. Reference was then made to the use of specific names such as *ichthyosis*, *papilloma*, *keratosis*, *nævus*, as well as the qualifying lines employed to designate the objective characters of the affections, and the author's conceptions of its natural origin.

The reader thought that more of the qualifications employed to

designate the surface characters of the eruption, such as ichthyosiform, verrucose, keratotic, lichenoid, etc., were generally applicable. Likewise, the qualifying term, *unius lateris* should also be dropped as unilaterality is not peculiar to this form of nævus. The term linear or striated should be retained as it expresses the most distinctive characteristic, and constitutes the type form of the disease.

After considering the various arguments used in support of the neuropathic origin of the affection, and deciding that they were not sufficiently supported by clinical evidence or anatomico-pathological proofs, the reader concludes that the term "linear nævus" sufficiently identifies the affection while possessing the advantages of simplicity and conciseness.

The Various Forms of Pityriasis and their Relation to Erythema, Eczema, and Psoriasis.—Presented by DR. G. H. FOX.

DR. JOSEPH GRINDON: I believe there is a special curse pronounced somewhere in the Old Testament against those who have wrought confusion in Israel. I suppose that Dr. Fox would say that he is the last to lay himself liable to that anathema, since he has set himself to do away with some confusing terms. There is need for a pruning off of redundant titles in dermatology, and especially in this group of cases, as to which we are in some confusion, not to mention our unfortunate students.

But it is a question to my mind whether the best way to obtain simplicity is to bring together such a wide variety of cases, even though they seem to merge into each other at some points. Take, for example, the ordinary seborrhea corporis, seborrheic eczema or "flannel rash," and its resemblance to Gibert's disease. I have had a patient come to me with a single lesion, with a buff center and a slightly scaly periphery, which I diagnosticated as seborrheic eczema, and yet when he returned with a number of small lesions, perhaps two weeks later, I changed my diagnosis to pityriasis rosea. That shows that the disease, in its early form, is so similar to seborrheic eczema that I cannot always make a differential diagnosis. But similarity and identity are not the same thing. Gibert's disease is well mapped out, and when we consider its preference for the female sex—although I have seen marked examples in the male—its liability to occur more particularly on the thorax and the external and posterior aspects of the arms, its course beginning with a single lesion, and after about two weeks the occurrence of a generalized crop, but more than all, what seems to be its auto-inoculability, we must admit that it constitutes a clinical entity. There is no question that we see cases of psoriasis, for example, in which the scales are greasy. Perhaps others would call them dry seborrheic eczema, but we should not for that reason erase the boundary between the two affections. I fear that if we proceed too rapidly in our generalizations we may possibly make "confusion worse confounded."

DR. J. N. HYDE: Mr. Chairman:—I was much interested in what Dr. Fox has said. We are under obligations to him for calling our attention to the well-known fact that several diseases do shade into each other in such a way as to make it difficult, if not impos-

sible, to distinguish between them. He might have even gone further. The French say that cases of pityriasis rubra pilaris are often indistinguishable from psoriasis and eczema. I have seen a man with an initial lesion, enlarged inguinal glands, and a syphilitic exanthem, covered with lustrous, shining scales, exactly resembling those seen in psoriasis. We all recognize the fact that symptoms of several diseases merge into each other; but this being to a certain extent admitted, a sharp line must be drawn between, for example, pityriasis rosea and all forms of seborrhea. I do not say that we can in every case distinguish between the two at a glance, but one can well be surprised at the rapidity and accuracy with which they differentiate the two in France. Pityriasis rosea is always distinguishable from seborrheic eczema. The first disease runs usually a definite course, while in almost all cases of seborrheic eczema the patient is obviously a seborrheic subject. There is often a coincident affection of the scalp, an acne of the face, or signs of seborrheic trouble about the nose.

DR. F. J. SHEPHERD: It seems to me that instead of simplifying, Dr. Fox has rather complicated the nomenclature by adding a new disease. All these diseases do run one into the other, and, as Dr. Hyde says, I do not believe in the new name. I believe most of these diseases described are parasitic in their origin. They are all probably of a cognate character, having a seborrheic origin.

DR. L. A. DUHRING: I tried to follow the remarks of Dr. Fox, and I think I succeeded in part. The subject interests me a great deal. I would state in the first place what I understand Dr. Fox to mean by his remarks. He has brought some photographs to our attention, in two series upon the wall. If I understand him, the upper line represents what he conceives to be different manifestations or varieties of one disease, which he proposes to call "pityriasis;" on the lower line there are representations of psoriasis. They resemble one to another in many instances pretty closely, and so it is often difficult to make a diagnosis between them. If I further understand Dr. Fox, as to the use of the term "pityriasis," he rejects all adjectives and merely uses the one word "pityriasis" to designate all of these diseases. I am not sure whether he is willing to admit that pityriasis rosea is distinct from his "pityriasis."

As I look at this matter, based upon my clinical experience, I would state that I recognize several diseases which, in their general aspect, are sufficiently different to warrant us in giving distinctive names to them. In the first place, as to pityriasis rosea. That disease has a well-defined clinical identity. I think most of us have seen many marked examples of it. In my experience the disease is not common. Nearly all the cases that I have seen of pityriasis rosea have been tolerably well defined, so that there has not been much difficulty in making a diagnosis. Fifteen or more years ago I presented before this Association a number of cases of this disease. It was pretty accurately described abroad by several observers before I brought the subject to the attention of this Association. I have seen little reason to change my views. I have seen many cases

since of the same disease; and in eight cases out of ten they have been pretty well defined. The disease usually pursues an acute course. It may, however, last three or six months, or a year.

Then I further recognize "seborrhea," as I have described that disease at length on several occasions within the past twenty years. I am willing to stand by my original views on this subject. It is not eczematous when typically expressed. It may attack any part of the body in which the sebaceous glands are active.

We have to deal sometimes with eczema, which may become complicated with seborrhea, and to which I believe the term *eczema seborrhoicum* is appropriate. It is a peculiar combination of eczema and seborrhea, as its name indicates. I think it is a proper term for certain cases that we are meeting with, and often has a well-defined clinical aspect.

Then still further, there are other diseases which simulate these diseases, more particularly *pityriasis rosea* and seborrhea. Many of these cases are difficult to define, because they simulate the diseases I have mentioned, and also *psoriasis*.

In conclusion, after the remarks on *pityriasis* and seborrhea, I will say that I am unable to agree with the observations of Dr. Fox, in which he takes the ground that all these several forms of disease having a general character of a more or less erythematous or inflammatory base, accompanied by branny desquamation, should be grouped under the name *pityriasis*. I mean, of course, all the diseases which are not manifestly eczema or *psoriasis*. I confess to be somewhat in doubt as to what he means in the use of the term *pityriasis rosea*, and shall have to call upon him to express himself, if he will later, as to whether he recognizes clearly *pityriasis rosea* as a distinct disease or not?

The great objection at present to the use of the term *pityriasis* alone, in the present state of our knowledge, is that if we were to adopt the word "*pityriasis*," we shall have to give it a clearer definition than now obtains. The word used alone means merely a superficial scaling. In nomenclature we must accept that which has been defined until somebody restricts, enlarges, or clarifies the subject, so that it again becomes clear perhaps in another aspect. If several writers should study a certain disease carefully and accurately, and give a great deal of information about it, and call that *pityriasis rubra*, or *pityriasis*, etc., etc., we must accept that term until a better name is proposed. Now, Dr. Fox proposes *pityriasis*, but he does not define it, and it seems to me from the standpoint of a teacher, that it is hazardous to accept anything until it has been clearly defined. With Dr. Fox "*pityriasis*" alone stands for a large group of diseases; but I am inclined to think that his group is too large to be useful. It is really a group of diseases, as he says himself, and it is not one disease. I am not in favor of calling a group of diseases by one name unless we are able to make distinct varieties of that disease. I think we need not only names of diseases but also of varieties. *Pityriasis rosea* has such a clear distinction in the minds of dermatologists generally that it is really a disease. It is as much

a disease as psoriasis, acne, or eczema. When a name stands for a well-known clinical affection it should not be disturbed. I am sure Dr. Fox's intentions are of the best, but his views seem to me to be too broad to be useful.

I would remark here that photographs of the skin are extremely valuable, and there is no one in the dermatological world who has done more to elucidate and exploit this matter from a clinical aspect than Dr. Fox. I think the profession at large are under obligations to him in this direction. The time is soon coming when the excellent results to be obtained by photography will be appreciated more than it is to-day. I do not think, however, that it is possible for any one to make a correct diagnosis in certain diseases of the skin from a photograph alone, nor even from a colored picture alone. They must be viewed, therefore, in the light of aids. Frequently they are of immense help in the matter of diagnosis; but we must not lay too much stress upon the outline of the lesions, patch, or patches, etc.

DR. FORDYCE thought it highly desirable to simplify our dermatological nomenclature but he failed to see how it could be done in the class of cases mentioned by Dr. Fox.

In certain of their stages marked clinical resemblances are often seen in the affections mentioned by the reader of the paper.

Their mode of onset and clinical course differ, however, in so many respects, that he failed to see how they could be included in one general group.

Until our etiological knowledge is more definite our nomenclature must necessarily be imperfect, and it is likely that a strictly scientific nomenclature will never be possible.

DR. A. R. ROBINSON: Mr. President:—I am in thorough accord with the remarks of Dr. Duhring. I believe that in these inflammatory affections of the skin, particularly and especially when the process is superficially situated and erythematous in appearance, future observation will enlarge the number of diseases instead of lessening them. It is a well-known fact that different factors can produce inflammatory symptoms that to the naked eye appear very similar, yet I am convinced that careful microscopical studies under improved technic will show the error of regarding conditions now described under one term and the necessity of separate description. I would therefore regard Dr. Fox's argument as an invitation to take a backward step, which would interfere with therapeutic progress also. I feel satisfied that before long there will be a great advance of knowledge in the conditions now described under the terms cancer and eczema as well as in the group of diseases discussed by Dr. Fox, and that the knowledge will lead to an increase in the nomenclature and not a diminution.

SECOND DAY—WEDNESDAY, MAY 5TH.

DR. H. G. KLOTZ of New York read a paper with the title:

Strong Solutions of the Ichthyol Group in Acute and Chronic Inflammatory Conditions of the Skin.¹

Dr. Klotz has applied ichthyol, thiol, and tumenol, in fifty-per-cent.

¹ Will be published.

aqueous solutions, or in a ten-per-cent. tincture, with good results, even in the most acute stages of dermatitis. They are particularly valuable because they rapidly dry, forming a thin cover over the affected parts without further dressing. Their effect is due to contraction of blood-vessels and to antiparasitic qualities. Besides the well-known use in erysipelas Klotz has employed ichthyol in dermatitis venenata (rhys), dermat. calorica (ambustionis and congelationis), dermat. traumatica (intertrigo), herpes zoster, eczema (acute and exacerbations of chronic). It is also recommended in erythema multiforme, dermat. herpetiformis, urticaria, and in the acute exanthemata. In chronic eczema, etc., periodical applications greatly accelerate the disappearance of infiltration, particularly if preceded by cauterization or stimulation, with diluted liq. potassæ.

DR. E. B. BRONSON: I regard ichthyol as one of the most valuable remedies in diseases of the skin that we possess. With regard to its action it appears to be exhibited chiefly in controlling hyperemia. In this it is closely allied to resorcin, but has a certain advantage over the latter as an anticatarrhal agent. The chief objections to ichthyol are its unsightly appearance and odor. But the odor is in most cases not very marked after it has been applied, and both objections are insignificant compared to the valuable effects produced. When applied in a watery solution it dries rapidly, and the smell is scarcely noticeable. In applying it I have found it best to use a broad varnish brush, painting it on freely and until the surface is well darkened. Another form useful in limited area is the *virnissum iels* of Unna. I have not found Unna's formula for its preparation quite satisfactory, at least the published formula. It is best prepared by first boiling starch in a little more than its weight in water, and then add ichthyol in proportion of from thirty to forty per cent., and albumen in about two and one-half per cent. Resorcin may be prepared in the same way, and makes a perfectly transparent varnish, very useful in certain affections—such as lupus erythematosus of the face.

DR. L. D. BULKLEY said that he could confirm much that Dr. Klotz had said in regard to the value of ichthyol, but he had seldom used it in the percentages mentioned; although under certain conditions he had applied it in full strength to the skin with the best results. He would call attention to its value internally in certain cases, as Dr. Klotz had made no mention of its use in this manner. In certain cases of red nose, where there seemed to be no appreciable cause, he had found that taken in doses of from five to fifteen drops, in water or capsules, half an hour before eating, it had proved very effective, and he had a number of patients who themselves returned to its use when this recurred.

DR. C. W. ALLEN: Mr. President:—There is not much that can be said to the members of this Association to-day about ichthyol, but there was a time when a great deal could be said about it. Dr. Jackson read a paper several years ago upon the value of ichthyol and resorcin in skin diseases based upon a clinical study of those drugs, and reported practically that they were of no use in derma-

tology, Now, he did me personally a great deal of harm by this report, because for two or three years acting on his estimation of these drugs, I neglected to use them, while in point of fact there are no two drugs in the whole list of recent remedies so generally useful as ichthyol and resorcin.

I was going to speak of the internal use of those drugs which Dr. Klotz did not mention. I find ichthyol of great value in a great variety of conditions associated with stomach and intestinal fermentation, so-called dyspepia, etc., as well as externally applied in the parasitic diseases, and especially in erysipelas. It is a late day to speak of ichthyol in erysipelas. I have read papers twice upon it in this Association, and I do not think they made much impression. At the meeting in Montreal I read a paper reporting fifty cases treated by ichthyol exclusively, and I have since continued to use it with good results in a large number of cases.

The use of tumenol has this advantage over ichthyol which Dr. Bronson has neglected to note; that it affects itching very much better and more quickly than does ichthyol. In acute erythematous and inflammatory conditions, and very pruritic eczema, if he will apply tumenol with his starch varnish or plasment, covering up the parts, he will give the patient more prompt relief than with ichthyol.

The Nature of the Xanthomata¹ was the title of a paper presented by DR. S. POLITZER of New York.

The peculiar yellow plaques and nodules in the skin known as xanthoma have been the subject of extensive studies on the part of pathologists and dermatologists, ever since they were first described by Addison and Gull in 1850. The greatest diversity of opinion exists as to their nature. This is due probably in part to the fact that different authors have examined different stages of the disease, and in part to the fact that the different forms of xanthoma have been assumed to be merely different clinical manifestations of the same process. The author's histological studies are based on thirteen cases—five of them cases of xanthoma planum palpebrarum, four of xanthoma tuberosum, and four of xanthoma diabeticorum. The clinical grounds for separating xanthoma of the eyelids from multiple xanthoma are as follows: The nodules of xanthoma multiplex are firm, round, elevated papules; the patches of eyelid xanthoma are soft plaques in the level of the skin. Eyelid xanthoma persists through life; multiple xanthoma sooner or later undergoes involution. Eyelid xanthoma is quite common; multiple xanthoma is extremely rare. If the eyelids were in this preponderating degree the seat of predilection for a common xanthoma, we should expect to find the eyelids affected in every case of multiple xanthoma; but, as a matter of fact, the two forms are rarely associated in the same individual. With the extensive material at his command the author has been able to show that common eyelid xanthoma is not a new growth, but is due to a degeneration of pre-existing, embryonally misplaced muscle tissue. The so-called xanthoma cell is a fragmented muscle fiber in a state of granulo-fatty degeneration,

¹ Will be published.

with proliferation of the muscle-cell nuclei. The various stages of the change from normal muscle fiber to "xanthoma cell" were demonstrated in sections under the microscope, drawings made by Dr. Ira Van Giesen, and microphotographs. This explanation of the origin of eyelid xanthoma harmonizes with a number of hitherto unexplained clinical and pathological facts, *e.g.*, the absence of any clinical signs of tumor; its almost exclusive occurrence in the face, where peculiar muscular conditions prevail; its heredity; its usual development after middle age, when degenerative processes are apt to occur; the peculiar yellow pigment that is always present in muscles undergoing fatty degeneration, etc. The structure of multiple xanthoma is shown to be wholly different from that of eyelid xanthoma. It forms a sharply circumscribed tumor in the cutis. It is an irritative hyperplastic development of connective tissue, whose cells produce fibrous tissue on the one hand, or undergo fatty degeneration on the other. In diabetic xanthoma the process is a little more diffuse and the tendency toward fatty degeneration more marked than in the non-diabetic multiple xanthoma. In both, irregular patches of granulo-fatty matter, interspersed with cellular detritus, occur in the middle of the nodules as the results of the fatty degeneration of the cells. In over eighty-five per cent. of the recorded cases of multiple xanthoma, far too large a number to be accounted a mere chance, there was either diabetes or some severe lesion of the liver with jaundice. The author thinks it likely that further research may show that the fibrous nodes and fusiform enlargements of tendons in chronic rheumatism are to be placed in the same general class as the nodes of xanthoma. We should then have a large group of diseases, hepatic, diabetic, rheumatic, all characterized by toxemic conditions, in all of which irritative connective-tissue lesions occur in the skin and elsewhere. At one end of this series we should have the persistent fibrous node of rheumatism; at the other, the transient nodules of diabetic xanthoma, while between them, intermediate in its tendency toward the formation of fibrous tissue and fatty degeneration, ultimately undergoing involution, would stand the nodule of common multiple xanthoma.

DR. W. H. WELCH, President of the Congress, spoke a few words, urging upon the members of the Association the importance of the study of the pathology of the skin with reference to questions of general pathology.

DR. J. N. HYDE: We are apt to think of the generalization of eyelid xanthoma as occurring upon the hands and elbows and knees. But there are four gentlemen in this room who saw a remarkable case in London last year, of a generalized xanthoma. In that case (of a woman) there was unquestionably no mere change of hue of the general surface, but a xanthomatous transformation of the whole surface of the thorax, without lesions on the hands and elsewhere.

In the instance of a woman who desired to use a strong solution of bichlorid of mercury for the destruction of parasites, the fluid was accidentally dashed upon the face, and eyelid xanthoma developed. Once in my experience have I seen diabetes with eyelid lesions only.

The patient was sent to me by a gentleman who devotes himself to the disease of the kidneys. Apart from localization upon the lids, there are curious expressions of xanthoma upon the general surface of the body. In all the cases which I have seen up to within six months ago, xanthoma of the hands had been limited to the palmar surface, and to nodules upon the backs of the fingers. But six months ago I had the opportunity of seeing a girl fourteen years of age, with remarkable looking dumb-bell shaped nodules upon the palmar surface of the fingers, and bulbous nodules deforming several of the digits.

Our essayist well said that "everything yellow was not xanthoma." As to xanthoma diabetorum, I will call your attention to two cases illustrated by portraits in the other room. The term xanthoma diabetorum is misleading, as the disease does not always occur in diabetic patients. It is a temporary condition, the eruption disappearing soon after the sugar is no longer found in the urine. In the second of the cases there was abundant glycosuria associated with albuminuria in a man with a large belly. The eruption vanished after disappearance of the sugar, but the albuminuria persisted. This is an interesting fact. Up to the date of our assembling here, we had, I think, less than thirty cases on record. Our essayist has referred to one or two non-recorded cases, and I report two more, so that we may infer that the disease is not so rare as we had supposed.

DR. F. J. SHEPHERD: I should like to draw attention to a case of xanthoma multiplex which occurred in a woman who suffered from jaundice due to obstruction from gall-stones. I relieved the obstruction by operation and the xanthoma disappeared in a very short time. I do not know if there is another case on record of the same kind. This case was shown at the meeting of this Society in Montreal.

DR. C. H. ALLEN: I may not pretend to discuss the histological features of the paper. I do not see how any of us can until similar observations and studies have been made in the same direction. I wish to join in congratulating the Association on the new acquisition and the creditable paper we have just heard read. At the meeting last year, in a paper on glycosuric dermatoses, I took the ground that we should not include these cases in diabetic dermatoses but should call them glycosuric eruptions. I have always clinically separated the xanthoma of the eyelids from the generalized eruption upon the body, the multiple form. They do, however, occasionally occur together, a subject of the eyelid form may develop the multiple form. The whole question is a very interesting one.

DR. JOHNSTON: I am at a disadvantage in having heard only the *résumé* of the paper, in having had little time to examine the specimens and in having but two cases of xanthoma, one of xanthoma diabetorum, the other of xanthoma tuberosum, with which to compare them. In the first, undoubted evidences of inflammation were present, edema, mitosis, leucocytic infiltration, etc.; in the second no such signs were seen. That the so-called xanthoma cells in both forms may be of

connective-tissue origin, cannot be denied, but I fail to see how this fact places the two in the same category. Aside from pathological findings, the clinical course, which must always be taken into account, is totally different. Diabetic xanthoma appears and subsides correspondingly with the diabetic symptoms; when xanthoma vulgare disappears, as it does in very rare instances, the regression is not dependent so far as is known on any systemic disturbance, and no relapse has been reported in such a case. It is difficult to conceive any tumor which is capable of relapsing in such a manner as did my case of diabetic xanthoma. In this man, 2,500 lesions at least developed over the surface in the short space of three months.

I must take issue with Dr. Hyde's statement that sugar is always absent at some time from the urine of these patients. It fluctuated in my case from 0.5 per cent. to 6 per cent. but never disappeared until his death. Fatty degeneration is easily seen in the xanthoma cells in Dr. Politzer's preparations, even in those hardened in alcohol.

DR. MORROW: I shall not attempt to discuss the scientific aspects of Dr. Politzer's paper, but refer only to one or two clinical points. One is the tendency to recurrence, which Dr. Politzer asserts is a characteristic of these cases. Some years ago I reported a case of xanthoma tuberculatum, in which the lesions were distributed very thickly upon the soles and upon the anterior surfaces of the leg, especially over the knee-joints. That case has been under observation for a number of years. There was to be noted a constant tendency to the recurrence of these lesions after they had been removed, in a manner which I indicated in my paper, by the application of strong salicylated plasters (twenty per cent.) which seemed to soften and disorganize the xanthomatous nodules, after which they were readily scooped out by the dermal curette.

The wife of the patient was in my office only a few days before I left New York, to report the further progress of the case. I had not seen him for two years, and her statement was that he had pursued this treatment for a long time, notwithstanding the tendency to repeated recurrence, until finally the disorder had ceased. It may be questioned whether this result was due to the treatment faithfully carried out, or to the spontaneous limitation of the disease.

I am fully persuaded that there is some direct causal connection between glycosuria and the so-called xanthoma diabeticorum. In all the cases reported under this head, with the exception, perhaps, of two or three, sugar was present in a greater or less quantity, and the general course of the eruptions, its exacerbation, and retrogression were conditioned or modified by the fluctuations in the quantity of sugar. In one case (Besnier's) he suggested that there was probably intermittent glycosuria, and in all these cases, where sugar was not found, it was probably because the examination was not made at the proper time.

We must admit that, clinically, xanthoma diabeticorum is altogether different from xanthoma multiplex. The rapid evolution,

spontaneous involution of the eruption, the firmness and solidity of the lesions, the yellow tops of the papules, the absence of striated patches, combined with the presence of inflammatory and subjective symptoms, make up a clinical picture entirely different from that of xanthoma.

DR. BOWEN wished to express his appreciation of the paper, and of the histological specimens. The theory of the origin of the xanthoma cells was a plausible one, although he did not think it fully shown by the specimens.

He considered that Dr. Politzer's position would be strengthened if he could show transitional forms, which were not, as yet, evident. He hoped the work would be substantiated by further studies.

DR. SHERWELL: One of the cases referred to by the reader of the paper, as reported by Dr. Robinson, was furnished the doctor by myself, knowing his connection and great interest in the matter. It occurred in a woman, and the eruption was present in the usual locations of glycosuria xanthoma. Her glycosuria was but a transient one, pronounced enough at first, while seen by me, but soon disappearing under the doctor's treatment. That was in a woman at or about middle age.

Another case, however, which he remembered well came under his notice shortly after in the person of a man about the same age. There was the same distribution on nates, elbows, etc., as in the prior case: more pronounced, however, and papular, almost tubercular, in character. He had examined urine with full expectation of finding sugar. None was present, or any history of symptoms implying that at any time such might have been present. In that case, too, there seemed to be no evidence of hepatic trouble; though he reported himself many years ago he is now living and remarkably healthy. On asking him about possible liver trouble at the time of examination—he is an authority in criminal cases—he gave me decidedly negative answers, but mentioned that he was credited with having “plenty of gall.”

DR. S. POLITZER: Permit me to express my thanks to the members of the Association for the very kind way in which they have received my contribution. It has been a source of great gratification to me, permit me to say so, that I have been able to make my début before this Association with a communication that may add something to our knowledge of xanthoma.

In Dr. Hyde's case of xanthoma of the eyelids, following a severe dermatitis, the conditions for the development of the xanthoma may have preexisted, so that the xanthoma would have developed independently or else the dermatitis directly provoked a degeneration of superficial muscle-fibers, thus producing the xanthoma.

The association of xanthoma of the eyelids, with glycosuria, can be looked upon only as a matter of chance. Both these conditions are not uncommon after middle age and it would be strange, indeed, if they were not occasionally associated in the same individual. I have had no experience at all with the diffuse forms of xanthoma to which reference has been made—those diffuse patches

that occur in the face and quite commonly along the lines of the palm. I think it quite likely that in those two locations the xanthoma represents the two different types; the xanthoma of the face is probably in most cases of myogenetic origin, while the xanthoma of the palm belongs to the class of the generalized xanthoma. Like the generalized xanthoma, it frequently undergoes involution and disappears. This course has been noted several times, so for instance in the case published in the Atlas now being issued from the museum of the Hôpital St. Louis, in which it is expressly noted that the lesions on the palms disappeared after a time.

I am entirely of the opinion of Dr. Hyde and Dr. Allen that the diabetes *per se* does not provoke the occurrence of diabetic xanthoma. I do not suppose that it is the presence of sugar in the blood that causes these lesions. I think it probable that there are some products of disordered metabolism that are common to diabetic conditions, to rheumatic conditions, and to some diseases of the liver that are responsible for these lesions. It is not at all impossible that it is some crystalline substance that sets up the irritative connective-tissue process that we know as multiple xanthoma.

As to whether the process in multiple xanthoma is inflammatory or not, that is purely an academic question, the answer to which will depend on our definition of inflammation. In a certain sense the common as well as the diabetic multiple xanthoma may be said to be inflammatory, but as Cohnheim understood inflammation they are certainly not inflammatory. Where there is an active connective-tissue proliferation there will, of course, be a certain amount of white blood-corpuscle emigration, but I have never seen enough leucocytosis to warrant us in calling it an inflammation in the sense of Cohnheim. I can, however, readily believe that a greater degree of irritation—greater than in any of the cases that I have seen—would result in the effusion of a notable quantity of serum and a more marked leucocytosis.

I am glad to have the corroborative opinion of Drs. Johnston and Fordyce on the presence of fat-granules in the clear spaces in the specimens of multiple xanthoma. Some of the gentlemen who had seen these foci of degeneration before, after hearing my paper expressed to me privately a doubt as to the fatty nature of this degeneration, though they had no theory to offer except that the clear spaces represented some kind of hyalin degeneration. All doubts as to the nature of the degeneration in question would be dispelled by examining specimens that had been properly osmicated, as in Dr. Fordyce's specimens from Dr. Morrow's case, and in my own specimens in which the degenerated spaces are entirely black; or by examining alcohol specimens mounted in glycerin, which show details of the structure that are lost in Canada balsam specimens.

There are a number of cases on record of diabetic xanthoma without glycosuria. I cannot agree with the opinion that has been expressed that in these cases glycosuria occurs, but escapes observation because the sugar is present only intermittently. In some of the recorded cases particular attention was paid to this point, but

repeated examinations failed to detect sugar. Permit me to refer again to Colombini's case of diabetic xanthoma in which there was no glucose in the urine, but large quantities of pentose were discovered on making the appropriate tests. It is likely, I think, that other, perhaps still unknown, substances regularly occur in the urine in both forms of multiple xanthoma that escape our ordinary methods of examination. At any rate both the common multiple and the diabetic xanthoma must be looked upon as an indication of a grave systemic disturbance. Dr. Shepherd's case of multiple xanthoma, disappearing after the removal of biliary calculi by cholecystotomy, is of extreme interest and forms a pendant to my own case, in which a fresh eruption of xanthoma lesions followed a succession of attacks of biliary colic. The fact that in over eighty-five per cent. of the recorded cases there was glycosuria or some severe lesion of the liver, makes a strong case for the opinion I have expressed that generalized xanthoma is a disease dependent on toxic conditions of hepatic, diabetic, or rheumatic origin.

A Contribution to the Etiology of Congenital Ichthyosis. Report of a Case with the Absence of the Thyroid.¹—By DR. JAMES M. WINFIELD of Brooklyn. Microscopic Report by J. M. VAN COTT, M.D.

The subject of the report was the second ichthyotic baby born in the family. There were five other children who were healthy in all respects.

The first ichthyotic child was reported by Dr. Sherwell before the American Dermatological Association in 1894. Each ichthyotic followed a severe fright during pregnancy.

On autopsy the reported case revealed the complete absence of the thyroid.

The examination of the skin by Dr. Van Cott showed the ordinary changes of ichthyosis with the occurrence of micro-organisms about the lymph spaces.

In reasoning from the above findings, Dr. Winfield concluded that the ichthyosis and allied diseases might be produced by the absence of the thyroid.

Regarding the presence of micro-organisms in the skin, he argued that as the thyroid had some inhibitory action upon the production of bacteria, it was possible the presence of bacteria in this case was also due to the absence of the thyroid.

DR. S. SHERWELL had been much interested in Dr. Winfield's paper, and his report of autopsy, etc. It comes as a succedaneum to a case of same character, occurring in same family and reported by himself at the last meeting of the Association at Washington, 1894. It is interesting to note that in the interval between that and this case the woman had been delivered of a fetus at nearly full term apparently, as to skin, etc., perfect in all respects, and in this connection also, to note that in both the pregnancies followed by the two ichthyotic births she had been exposed to severe mental shock and perturbation, causing great nervousness, etc., while in

¹Will be published.

the one intermediate, as well as in the gestation period of her prior healthy children such events, or at least nothing worth noting, had occurred. Personally, he was inclined to lay a good deal of stress on this as an etiological factor.

The one quite important fact demonstrated by the post-mortem examination, that of total absence of the thyroid gland, is a decidedly curious and may be important one, how much so, of course I cannot say, but there may be yet attached a good deal of significance to it.

As to the question of heredity which always comes up in these cases, he did not at least consider it proven, or even likely as far as he could judge; certainly, both the avowed parents, and especially the mother were well-nourished people, apparently happy and contented in their domestic life. He saw this child by request of Dr. Black but once on the second or third day after birth, the mother absolutely refusing to nurse it; it was transferred to the Flatbush Hospital where it came under the care of Dr. Winfield.

DR. BOWEN: The report of Dr. Winfield's case confirms me in the belief that under the head of ichthyosis congenita, two distinct conditions have been described; one is that illustrated by the reader's case, and to which the name keratoma is more properly applied, as its close relationship with ichthyosis has not been proved. A second condition which I have observed in one case, and of which two other cases have been described in France, is owing probably to a persistence of the embryonic epitrighial layer.

DR. WINFIELD: I have very little to say except to thank the gentlemen for their kind reception and discussion of my paper.

I fear that Dr. Gilchrist misunderstood my remarks regarding the organisms. I did not claim them to be etiologically responsible for this case of ichthyosis; I simply reasoned that the absence of the thyroid in this case might have been productive of the micro-organisms found in the skin.

The suggestion of Dr. Bowen appears to me to have considerable weight, and I shall endeavor to follow up that line of study.

The only point I wish to emphasize is, that the absence of the thyroid might be responsible for many cases of ichthyosis congenita and allied diseases.

A Case of Hereditary and Continuous Shedding of the Finger-nails.—By DR. D. W. MONTGOMERY.

The patient, a native of France, was a strong, healthy man of 35 years of age, who had been troubled from birth with a constant shedding of the finger-nails. He stated that his mother's nails fell like his own, one or two nails being affected every seven or eight months. He had two maternal uncles whose nails fell every three years or so. Other members of the family on both sides had bad nails but the patient could not say that they fell off. His immediate family have no affection of the nails.

There were no stigmata of hereditary syphilis, no indications of psoriasis nor eczema, none of the generalized exfoliative diseases of the skin nor of any constitutional disease whatever, except a recently acquired syphilis which had no affect on the affection of the nails.

There was a small quantity of albumen in the urine, but the patient did not appear to be suffering from Bright's disease.

The patient said that one or two of his nails were constantly falling, six to eleven months completing the cycle. A nail first becomes a dull yellowish white over the lunula and then begins to lift away from the nail-bed from behind forward till it falls off. The shedding is completed in about three months after which the nail grows in again perfectly normal in from three to eight months. There were no subjective symptoms attending the process, and there was no order in which the nails were attacked.

DR. J. C. JOHNSTON: This subject of nail disease is one which has been sadly neglected. It occurred to me, during the reading of this paper, that I might, perhaps, offer a tentative explanation of the phenomenon. So far as my knowledge extends, no microscopic examination has been made in such a condition, but the theory may lead to it. It occurred to me that there might be a granular degeneration of the cells of the basal layer of the epidermis, accounting for the separation of the nail from its bed on slight traumatism. The condition of granular degeneration in that layer has been found by Dr. George T. Elliot, as a congenital defect, in another disease, which I do feel at liberty to name. It was that which gave me the idea.

DR. KLOTZ: Even if it was found that with a degeneration, as Dr. Johnston suggests, was taking place, the question of the etiology would not be much nearer solution. We would then again have to ask, what is the cause of the degeneration?

DR. D.W. MONTGOMERY: I did not make a microscopical examination of the nail-bed because of not having an opportunity of doing so, but I cannot see how a fatty degeneration would account for the affection. I cannot imagine a fatty degeneration of the nail-bed coming on in spells, and in the intervening time perfectly sound, strong, translucent, smooth, absolutely firm nails being produced. If the shedding were due to a fatty degeneration of the nail-bed the nails growing from such a nail-bed would in some way be continuously defective.

DR. WHITE: Did the others have sound hair?

DR. D. W. MONTGOMERY: Yes, the other members of the family were said to have had good hair. The patient had excellent, strong, black hair, and his teeth were of good size, hard and firm. His father's people had bad nails, brittle and crumbly, apparently like those in people having psoriasis or eczema. The patient's mother and one maternal uncle had the peculiar cyclic shedding of the nails such as the patient had, but otherwise their nails were said to be in every respect normal. The idea that it might be in any way allied to "the hereditary inclination to the formation of blisters," never occurred to me. There were no blisters, no history of particular vulnerability to traumatisms, no extravasations of blood, and no inflammatory reaction whatever. The shedding of the nails was absolutely painless.

Symmetrical Atrophy of the Skin. Report of a Case with

Colored Drawings and Photomicrographs.¹—DR. J. A. FORDYCE reported the case which occurred in a woman aged forty years.

The hands, elbows, knees, and ankles were the seat of atrophic lesions which were surrounded by a dusky-red zone of dilated capillaries. The atrophy followed closely on the hyperemia which seemed to be the primary condition. Clinically the affection resembled the cases described by Buchwald, Pospelow, Touton, Bronson, and others. The eruption was absolutely symmetrical and had up to a short time before been progressive. On microscopic examination the atrophy was found to be secondary to an inflammation which was located in the skin and underlying connective tissue. The epidermis was invaded by lymphoid cells which had produced a thinning and degeneration of its constituent cells. No organic affection of the nervous system could be detected, although there was evidence of vasomotor disturbance.

DR. KLOTZ: I have nothing to say in regard to the present case. I have myself observed two cases of the same type as Dr. Bronson's, one of which was presented to the New York Dermat. Soc. Both cases were apparently of traumatic origin, in one the lesion was located on the left forearm, principally the ulnar aspect, in the other, on the back extending from the lumbar region over both lower extremities. In both instances only the atrophic conditions were observed; whether any infiltration, swelling or inflammation had preceded the atrophy was impossible to decide.

DR. BRONSON: I have been greatly interested in the case described by Dr. Fordyce and also in the question whether the disease is identical with that in the case described by me. There are some points in which the two cases differ decidedly. In Dr. Fordyce's case the evidence of an inflammatory character was quite evident, while in mine it was wholly absent excepting at the lower part of the leg where there was some ulceration of a common type due probably to the impaired nutrition and loss of regenerative power. Again, in my own case there was a much more sharply defined border. At the groin which bounded the atrophic area this border was like a distinct ridge, the atrophic portion being sunken below the niveau. The blood-vessels which showed distinctly through the atrophied part suddenly disappeared as they entered the region of normal skin. Nevertheless, pathologically the two cases may be identical, representing different types of the same disease.

DR. DUHRING: I have been interested in Dr. Fordyce's paper. I would take the ground, from my study of similar forms of atrophic disease, that these cases may be regarded as representing the same process, notwithstanding the fact that signs of inflammation exist in some and are absent in others. The fact that these diseases are chronic, plays a somewhat important part in the general trend of the process. They are all characterized by marked atrophy, and hence I should be entitled to regard them as belonging to atrophies of the skin. There are three well-known affections which are characterized by atrophy, diseases in which atrophy is the ultimate outcome of the

¹ Will be published.

process, but which may be preceded by circulating or by inflammatory symptoms. These are morphea, trophic macules and striæ, and scleroderma. I think that when we estimate whether a disease should be grouped among the atrophies or elsewhere, we should take into consideration the prevailing process. This should determine the classification of the case.

THIRD DAY—THURSDAY, MAY 6TH.

Some Cases of Feigned Eruptions.¹—A paper read by DR. F. J. SHEPHERD of Montreal.

After a few preliminary remarks he narrated four cases of feigned eruptions.

CASE I.—A female servant suffering from a very peculiar eruption on the hands and forearms which had lasted ten days. The eruption consisted of a number of circular patches about the size of a ten-cent piece; some of the patches were quite dry, hard, and gangrenous, and almost black in color, others were shiny and of a dead yellowish color, and some were red and inflamed. In some of the thin patches a series of concentric rings could be made out; these patches had exactly the appearance of having been made by a metal disk applied hot to the skin; patient was confined to bed, and hands and arms bound up in starch bandages. No new spots appeared, and on taking down the bandage some patches were quite healed and in these the sloughs had come away, leaving granulating ulcers. The object of the woman was no doubt to escape work.

CASE II.—Elizabeth B., æt. forty-four, a sturdy, thick-set woman, cook on a farm, came complaining of troublesome blisters on the cheeks. She said that it being haying season she was pressed into field work. On going to bed she was quite well but on waking in the morning her cheeks were red and inflamed and sore; huge blisters came out which soon coalesced, and when she was seen at the skin clinic each cheek was covered by one enormous blister; the cheeks only were affected—nose, eyes, chin, and mouth escaped. Edge of eruption was sharply defined. Once before haying had a similar effect on her. The case was looked upon as an eruption of artificial production by some acid. Object: to avoid field work.

CASE III.—Laura R., æt. twenty-eight, living at home, came to hospital complaining of an eruption on the chest. She said that two years previously croton oil had been applied to her chest for some lung trouble and that ever since, at intervals, a croton-oil rash had come out. She had a typical rash from croton-oil between her breasts and over her chest. From time to time she attended the clinic and took a great interest in showing the eruption to the students. A month later she appeared with each cheek covered by a huge blister, as in the last case, full of fluid; blister was confined to the cheeks. The rash on the chest had almost disappeared and she informed us that when the blisters came out on her cheeks the rash disappeared from her chest. The blisters lasted ten days. She came

¹ Will be published.

back several times, sometimes with blisters on the cheeks, and at other times with a rash on the chest. She presented all the hysterical stigmata, as insensitive lumen, throat, pain in the back of head, and limitation of vision. This was undoubtedly a case of feigned eruption, and its object was to attract attention and sympathy.

CASE IV.—This was a case of so-called *spontaneous gangrene* of the foot in a young waitress, aged twenty-four. Some years previously she had a severe attack of typhoid fever, followed by swelling of the left leg and foot. A year later gangrenous ulcers broke out on the dorsum and inner side of the same foot. She was treated in hospital, and the ulcers were slow in healing. The next year sloughing of the skin again appeared in the same foot and leg, but this time the ulcers left after the removal of the slough healed rapidly. Two years later severe sloughs again affected the same limb and when the dead skin separated skin-grafting was employed to heal the ulcers. In October, 1896, she was admitted to hospital for gangrene of the skin of the same foot. There were four gangrenous patches, the largest, measuring five inches by two, was situated in the dorsum of the foot, was slightly swollen, but the surrounding inflammatory reaction was very slight. The case was treated for several months before healing took place. The diagnosis of artificial gangrene was made by exclusion. The periphery of the foot was not affected, nor was the gangrene in the course of any nerves. Again, there were no symptoms of Raynaud's disease, the circulation in the extremities being very good. The girl was an inveterate cigarette smoker and an alcoholic. She enjoyed the excitement of hospital life and the interest her case excited among the medical men and students. A short time before leaving the hospital she rushed out of the ward kitchen, where at that time there was no fire, with her clothes ablaze. The fire was quickly put out by the nurse. Dr. Shepherd was of the opinion that the recurrence, with periods intervening of good health, and the fact that this corresponded to no known disease, were sufficient grounds for making the diagnosis. He suggested that the sloughs very much resembled those caused by the application of heat, such as that produced by hot-water bags. It is possible the lesions might have been caused by burning cigarettes, as this is a well-known method of mutilation among a certain class of women in Algeria.

DR. ALLEN: I do not think that we have a class of feigned eruptions which are distinct and separate from hysterical eruptions. It seems to me peculiar that there should be so many similar cases occurring in different parts of the world, affecting women of different nationalities, which should all be self-inflicted. I have seen one instance of cutaneous gangrene which I believed to be purely hysterical, although the lesions were such as to lead an observer to suppose they had been produced by design with the aid, perhaps, of an acid. I cannot conceive of a malingerer, unless it be one who has associated very much with doctors, who knows enough about those things to feign such a condition as localized anesthesia, which was

present in my patient. Such a case as that must be put down in the hysterical class.

Speaking of the effect of hot water-bottles—the photograph of the last patient shown suggesting the use of the water-bottle—if the patient were a hospital patient, where there was a chance to use a water-bag, it might be done without the doctor's knowledge. It is remarkable what an injurious effect a water-bag may have in persons recovering from ether. We cannot refer to the subject too often, and in at least three hospitals in New York they have taken the wise precaution, since I wrote an editorial on the matter several years ago and brought the matter up in several societies, to establish a rule that if an unconscious patient is put into a bed with a hot water-bottle, the nurse is discharged. The nature of the burn lesion is very much the same as that shown in one of the photographs presented.

DR. DUHRING: The first question in the consideration of this subject is to determine whether we are dealing with morbid processes, arising internally, or whether the lesions arise from external causes. I admit that this is often very difficult to decide, and sometimes impossible. But there is one point I wish to speak of; I do not think that we should state positively that the eruption is feigned or artificial until it has been proved. That does not seem to have been so in the case presented by the reader of the paper. He seemed in doubt himself whether they were due to artificial means, or were the result of disease. I think in the past it has been the practice of some writers on such subjects to report cases which have not been artificial. There are some cases of that kind reported within the past twenty-five years which have been shown by subsequent observation not to have been artificial eruptions. I do not think we do the matter justice in stating that we are dealing with artificial eruptions before we have proved it. On the other hand, it is well-known that factitious eruptions are met with from time to time. I took occasion to state yesterday that in my own experience I had seen but a few cases in my life. I recognize well, however, that such cases do occur in the practice of some other observers. But I am extremely slow to recognize that term "artificial eruption," because I am unable to classify it elsewhere.

Before coming to the conclusion that they are factitious, proof should be obtained. I have seen cases in which it was stated by one or two of the physicians in attendance that the lesions were factitious. I had reason to question the accuracy of the statements. I had the opportunity in one or two instances of following them up, and it was proved they were not feigned, but neurotic, hysterical diseases of the skin.

DR. GRINDON: There are instances of artificial dermatitis without feigning. The practice of Algerian prostitutes, burning themselves with cigar ends, reminds me of the case of a young man, thirty years of age, a well-educated gentleman, but "peculiar." He had lost a brother to whom he was very much attached. He was afraid that possibly this brother was suffering in another world, and he en-

tertaind the notion that he could help him by some form of vicarious atonement. He frequently burned himself about the arms with the end of a lighted cigar. Among other things he made on his arm a figure of a Latin cross with the cigar burns.

DR. M. B. HARTZELL: In all these cases of supposed "feigned" eruption, nothing is more difficult than to produce absolute proof. I recall an instance of a girl, eighteen years of age, who presented a peculiar series of excoriations on the forearm. As she was an ambulant patient it was impossible to detect her in the production of these lesions. But they had probably been produced by the finger-nail or some sharp instrument. When the arm was bound up, so that access was not possible, the lesions healed and no new ones appeared. That was not absolute proof, I know. And yet here, while absolute proof was wanting, while no one saw her produce the lesions, there could be no doubt but they were artificial in character.

DR. BRONSON, referring to the injuries produced by applications of hot water-bottles or bags to the lower extremities, observed that in most of these cases the patient was suffering from shock, collapse, paralytic stroke or other like conditions, in which there was great impairment of the vitality; and that, while the burn might, in a measure, be attributable to the insensibility of the patient and his inability to complain, it was in all probability largely due to the loss of resisting power or increased vulnerability directly consequent on the lowered vitality. The effect was analogous to what he had stated it to be; that in the so-called hysterical or neurotic eruptions, which, though not feigned, were to a certain extent artificial.

DR. J. C. WHITE: I would like to say a word, and that is regarding a statement of Dr. Duhring, as to the diagnosis not being warranted by the facts. Circumstantial evidence must be depended upon in nearly all cases. There is probably not one case in a hundred of true "feigned" eruption where the patients are detected in the act. I would like to instance the last case I have seen of a "feigned" eruption: A woman of fifty or sixty years came to my clinic, presenting a dermatitis, characterized by deep excoriations, pustules, and ulcers, seated upon the upper lip and chin, in the form of a large circle. What evidence had I that it was a "feigned" eruption? Of course the configuration was highly suspicious. She denied absolutely that she had ever applied anything to her skin. Yet the affected area was the seat of marked hypertrichosis, and there was no doubt in my mind that she had been applying some strongly irritative depilatory to the affected area.

DR. SHEPHERD: I might make a change in the title "Eruptions Probably Feigned." There was no absolute proof in any of the cases, but I think one has to use one's common sense in this matter. I think some people can diagnose hysterical affections better than others. Some people are more easily imposed upon by women than others; and some men are imposed upon by special cases. A man without a sense of humor is always imposed upon by hysterical patients, and he cannot estimate the true value of facts. I think that

Dr. Bronson's observation is a good one, and that his suggestion offers a good explanation of burns from hot water-bottles. Water, not really boiling hot, and into which one could easily put one's hand, will cause serious burns in persons unconscious from ether. I saw a case in the Montreal General Hospital of very severe burns from hot water-bottles, and six months later the ulcers had not yet healed. These ulcers reminded me of burns caused by X-rays. Notwithstanding the absence of absolute proof, I still hold to my first opinion that the cases of eruption narrated were produced artificially.

What Conditions Influence the Course of Syphilis? (a) The Virus? (b) The Individual?—DR. R. W. TAYLOR of New York read a paper on "Its Adult Aspects," and DR. J. N. HYDE of Chicago a paper on "Its Infantile Aspects."

DR. I. E. ATKINSON: Mr. Chairman:—Dr. Taylor is so conscientious and intelligent an observer that it is very difficult to find weak points in his armor. There are two or three points I have noticed in the course of his paper of which I will speak. My first point would be the challenging his accuracy as to the diminution in severity of syphilis, within his observation. The course of the disease, I think, will hardly show within a human lifetime such a marked mitigation of the symptoms as to constitute evidence of a difference in its potentiality. There is possibly less syphilis now than twenty-four years ago. Not that syphilis has modified its intensity, but under the enormous increase of the facilities of treatment, it has been combatted better than ever. Twenty-five years ago, the facilities thrown in the way of persons who became victims of syphilis were not great; the hospital accommodations very small; the dispensary accommodations very poor. The poor of cities now-a-days have recourse at once to dispensaries for the slightest ailment. Formerly, the disease was more neglected. It oftener made great inroads upon the individual before he applied to the physician for relief. In one lifetime I do not think we could notice any distinct mitigation in the disease itself.

DR. JOSEPH GRINDON: This is such an enormous field, that I will only touch upon two points. Both readers seemed to take it for granted that in specific diseases, the quality or quantity of the virus is not a factor of such importance as the condition of the recipient soil. Judging from analogy, it seems to me that the quantity of virus introduced may be of importance. We have at least one disease in which that is the case. In vaccination, we know it makes much difference how much virus is introduced. How many abrasions are made in the first vaccination, and what area they cover. We might be inclined to think that it would make no difference whether much or little virus were introduced, but the tables published by Marson show that it makes a very great difference whether one makes one, two, three, or four abrasions. So, possibly, the *quantity* of virus introduced into the patient at the time of taking the syphilis has something to do with the final result.

Another point: Both gentlemen have that hopeful feeling about

syphilis which is common to syphilographers and dermatologists. We are the most hopeful people in the world about syphilis. Talk to neurologists; they are doubtful about its curability. And I have almost given up my hopeful views when the latter gentlemen have told me how often they come across post-syphilitic nervous disease in individuals who had been the subjects of good and apparently sufficient treatment, who seemed to fulfill Fournier's four conditions.

DR. HARTZELL: Mr. Chairman:—it seems to me this is largely a question of "soil." I have no doubt that the virulence of syphilis depends altogether upon the character of the individual, *i.e.*, upon the character of the soil in which the virus is implanted. If certain changes take place in the individual, the soil is so altered that the virus does not grow. On the other hand, there may be certain conditions which attenuate the virus. And it seems to me that if we reason from what we know of other infections, it must be a question of "soil." The virus is always the same; but it may change its character according to the soil in which it is implanted. If an attenuated virus is transferred to the proper soil, it assumes its former qualities.

DR. D. W. MONTGOMERY: I wish to ask Dr. Taylor about his use of the word "symbiosis." Dr. Taylor is so careful in applying terms that in all probability the meaning he has attached to the word is correct, yet it is not such as I have been accustomed to hear. I understand symbiosis to mean the coalescence of two cells in such a way as to give rise to a cell having different potentialities from either. The best example of a symbiosis is the union of the spermatozoon and the ovum to form a cell out of which may develop a complete being. The ovum alone seems often to be capable of going on to form an incomplete individual even in human beings, and the formation of ovarian dermoid cysts has been explained in this way, but in order to produce a complete fetus a union or symbiosis of both spermatozoon and ovum is necessary.

Klebs has used the term symbiosis in a somewhat different sense in trying to explain the extremely high vegetative activity of the cells in some malignant tumors. He supposes that parasites may enter individual cells, exercise a spermatogenic influence on them, and become so intimately fused with them that the resulting cells are something different from either compound and endowed with a tremendous vegetative activity rendering them most dangerous parasites.

Now Dr. Taylor has given quite a different meaning from the above to the term symbiosis. He says that supposing a tissue to be attacked by syphilis and afterwards to be also infected with tuberculosis, the whole three living elements, the tissue attacked, the micro-organisms of syphilis, and the tubercle bacilli all become intertwined so as to give rise to a conglomerate of symptoms differing from the symptoms of either syphilis or tuberculosis. That this compound disease may differ from either syphilis or tuberculosis may be true, but I do not think it constitutes a symbiosis, but rather syphilis with a superinfection of tuberculosis.

DR. KLOTZ: Having gone almost over the same ground as Dr. Taylor's paper in the article on the prognosis of syphilis in Morrow's system, I have nothing to add to what I have stated there. I am glad to find that my views do not materially differ from the speaker's. On the nature of the syphilitic virus all opinions are entirely hypothetical. I have published on another occasion my own views of the question, which I shall not mention here; to one point only I wish to call your attention: the alleged great similarity between syphilis and tuberculosis. In reality, primary and secondary syphilis have much more in common with smallpox and the acute exanthemata than with tuberculosis, while tertiary syphilis, particularly of skin, mucous membrane, etc., indeed resembles local tuberculosis so much that differentiation is often almost impossible.

I do not believe that the opinion can be upheld in such a general way that tertiary affections are always formed upon residua of previous secondary lesions. While I do not deny such an occurrence, I certainly have often observed gummatous lesions in regions which never had been occupied by secondary forms. It can be considered as certain, that the gummatous processes start from the blood-vessels. It seems, therefore, but logical to look to the blood-vessels and their contents as the seat of the etiological factor. I believe that the virus, whatever that may be, is circulating in the blood, and that usually some local condition or accident (trauma, overexertion of an organ) is responsible for the localization of the tertiary or gummatous lesion.

DR. FORDYCE said that the examinations which he had made of excised initial lesions confirmed the statement made by Dr. Taylor. He did not believe, however, that the grouping of small cells about the vessels at a distance from the induration explained the negative results obtained by excision.

In his opinion an infection of the general system had taken place at the time of or before the appearance of the chancre.

In endeavoring to account for the occurrence of severe syphilis we are aided by observing other infectious diseases. In such affections the poison at times seem to have acquired an increased virulence.

He considered that both the individual, the quality of the virus, as well as the quantity inoculated, were responsible in certain cases for the outbreak of a severe form of the disease. Individuals of middle age who lead a sedentary life, and in whom the food supply is greater than the waste frequently develop severe syphilis. It would seem, in his opinion, that such persons are more apt to develop sclerosis of the viscera or nervous system. Patients of this class, with a gouty tendency, whose blood-vessels are beginning to undergo pathological changes, probably offer less resistance to the action of the specific virus on the small vessels where the first changes in sclerosis probably occur.

DR. ALLEN said we have to consider both sides of the question, and take into account both the soil and the individual, and in certain cases the influence of the one will predominate over the other. When we come to reason by analogy, comparing syphilis with other infec-

tious diseases, we are met with many of the same difficulties. There are certain epidemics of diphtheria which are especially malignant. The children of a given institution or community are one year under very much the same conditions as another year as to their physical being and hygienic surroundings, but the children will all die in one epidemic and in another they will all recover. So far as that goes, we have the balance of argument in favor of the virus being at fault and not the soil. We all accept the fact that in certain run-down individuals, in tuberculous individuals, in individuals who have one or the other so-called diathesis, lues will take a peculiar course, showing more or less modified external manifestations. There are certain circumstances which go to show that the virus has at times a decided influence, and there is one case reported by a French observer, whose name I do not at this moment recall, in which a woman who developed nerve and brain syphilis and subsequently died, transmitted the disease to a large number of young men, some seven or eight of whom, as I remember the report, developed the same general nerve form of syphilis with early brain symptoms. I have within the past year been reminded of this possibility by having in charge two patients, both with cerebral syphilis, who had contracted the disease one from the other (which one had it first I am unable to say), but both have the brain and nerve form of the disease. We all, I am sure, occasionally meet with such instances which make one think that there is something about the virus which is peculiar in this way. I would like to say a word about the excision of chancre mentioned by Dr. Taylor. If, as Dr. Taylor claims, there is early diffusion of poison from this initial affection, I do not see why we should not excise the chancre in suitable cases, simply to eliminate so much poison. And I fail to see, although it has no direct bearing upon the question, why we should not begin our attacks upon the disease at once. While I agree with Dr. Taylor that extragenital chancre does not give a more severe infection than chancre upon the genitals, I further believe that the course can be only influenced for good by beginning treatment early. None of us could begin treating a case of syphilis as soon as the chancre was discovered and follow the case for a year without seeing some signs which would be confirmatory. The chief objection which has been raised to early treatment, that it leaves the case in doubt for all time is thus done away with. Such a thing does not exist. I begin the treatment of lues when I make the diagnosis in the chancre stage, and I have never seen an instance in which, during the first three months, there were not a few lesions upon the body or mucous membrane which confirmed the diagnosis.

DR. SHERWELL was accustomed to sit at Dr. Taylor's feet when the subject under discussion was syphilis, and agreed with him in what he believed were the speaker's conclusions that the different course and virulence of the disease were due more to the individual than the virus, which latter he thought was a pretty constant quantity, no matter how large or small was the primary lesion. In some minor points, however, he disagreed with the speaker. It had seemed to him, in a fair experience of the malady, that often in cases where

the disease had been engrafted on an individual with a tuberculous diathesis (Dr. Taylor's symbiosis) that the effect was almost antagonistic; in such individuals he (Dr. S.) had found that they responded to specific (antisyphilitic) treatment often with miraculous rapidity, the medicines acting apparently as hematic and reparative tonics, so that in his opinion, cure or relief from both diseases had followed. He did not, however, recommend inoculation of one upon the other as necessarily good treatment, any more than he thought the double fact rendered a case more hopeless.

Speaking as a pure clinician, too, he had been led to recognize and wonder at the conservatism of Nature in regard to the puerperal woman at least (frankly affected with syphilis) who often, and as it occurred to him, usually seemed to show very little evidence of the disease, and that easily controlled in his experience. A remark by previous speaker (Dr. Grindon) had attracted his attention, and he would like to have his authority, as to his statement, that the amount of vaccine matter, or amount of surface vaccinated, made a material change in the protective efficacy of such vaccination. He thought that the most minute contagion of vaccinia, as well as variola and syphilis as well, oftentimes caused the most serious manifestations of the respective diseases.

DR. MORROW: Mr. President:—I must express my pleasure at hearing these papers. I think that the facts were admirably presented and the conclusions of the readers agree, in the most part, with my own views. So far as the relative influence of the virus and the individual are concerned, my belief is that the quality of the syphilis depends altogether upon the idiosyncrasies of the individual. In other words, I think it is the "soil" and not the "seed" that determines the quality of the syphilis. We can only base our conclusions upon the study of clinical facts. Our theories with regard to the virus of syphilis drawn from analogies with the virus of other diseases are of very little value, because we do not know definitely what constitutes the specific virus of syphilis. There are certain clinical facts which at first would seem to indicate that in hereditary syphilis, at least, the virus has a certain influence upon the character of the manifestations.

Perhaps the strongest argument that can be adduced in support of the theory that the quality of the syphilis is determined by the virus rather than by the individual is drawn from the study of hereditary syphilis. There would seem to be a progressive attenuation of the syphilitic virus, as shown by the results of successive pregnancies in syphilitic women. The first pregnancies will result in abortions or still-born children, and later children may be born exhibiting mild manifestations or exempt from all taint. This might appear to indicate that the quality of the virus alone determines the character of the syphilis of the offspring. But it is not the specific element alone we should consider, but also the nutritive relations subsisting between the parent and her offspring. The mother transmits not only the specific taint, but she transmits a defective physical organization, with no stamina or capacity of resistance. In this

enfeebled organism she furnishes the soil most favorable to the spermination and growth of the syphilitic virus. As the syphilis of the mother grows older, the nutritive conditions of the child are improved, thus endowing the soil with a greater capacity of resisting the disease.

Turning now to acquired syphilis, an intelligent interpretation of the facts would seem to show that the quality of the virus in no way influences the character of the manifestations. The benignancy or malignancy of syphilis is independent of the source of the virus, whether it is derived from an active recent syphilis or from an old syphilis. At the meeting of the International Congress of Dermatology and Syphilography last year, there were a number of communications presented, notably one by Dr. Feulard, bearing upon this question. Well-authenticated cases of late infection were detailed five, ten, fifteen years, and later. The type of syphilis resulting from these late infections was in no way modified. The manifestations were just as severe as in cases of infection from a recent source.

Take again the phenomena of malignant syphilis. Malignant syphilis does not have a malignant source; it does not produce a malignant attack in another individual. It is due to a peculiar susceptibility of the affected person—the product of a soil apt to conceive and develop the syphilitic virus. The capacity of resistance on the part of the individual determines the benignancy or malignancy of syphilis.

I have not the time to take up the consideration of certain diathetic as well as extraneous conditions, such as privation, want, alcohol, bad hygiene, etc., which are recognized as factors of gravity in syphilis. But from whatever point of view we consider the matter under discussion, we may conclude that while a specific virus is the active efficient cause of syphilis, the quality or type of the disease is determined altogether by conditions peculiar to the individual.

DR. TAYLOR: The term symbiosis is used in medicine to represent the coexistent and seemingly amalgamated development of two pathological processes. I have no reply to make to the remarks of the gentlemen who do not endorse the views offered in my address. They are mine, and I can hardly modify them or change them. Dr. Klotz's essay was not read by me in the preparation of my address.

A Case of Porokeratosis (Mibelli) or Hyperkeratosis Excentrica (Respighi) with a Remarkable Family History.¹—Presented by DR. T. C. GILCHRIST of Baltimore.

The patient whom I exhibit is a young man twenty-one years of age, who has had the disease since he was five years old, when it commenced on his ears, nose, chin, neck, back of hands, and right forearm. The lesions were extremely slow in appearing and in growing. The most remarkable feature about the whole case is the family history, which is here given in a tabular form, together with a very brief description of the disease in each case.

¹ Will be published.

It will be seen that eleven persons in one family have had this disease. The patient gave me this history after careful inquiry, and I have since been able to verify his statements with reference to seven of the cases, *viz.*: father, three brothers, a married sister and two of her children, by personal observation. The patient's description of the lesions in his father and brothers, whom I examined later, was so correct that I feel confident the other descriptions are also true, especially since the remaining family history was verified by his father and mother. The father of the patient also described to me the disease as it existed on his mother, an uncle, and brother. I will not go any further into the history or description of the lesions occurring in other members of the family, but will reserve that for a more detailed histological description with photograph and drawings, which will appear later.

The patient first came under my care eighteen months ago, and my attention was then only directed to the lesions on the face. I did not diagnose the disease until I had made ten or more histological examinations of excised portions and had seen Mibelli's and Respighi's articles.

The eruption consists of lesions of various sizes and forms, which appear to take on two characters according to their age. The smallest variety, which are distributed chiefly over the face, consist of minute (less than one mm. in diameter) dirty brown, semiglobular elevations of a horny nature. When they reach the size of a small pinhead the center becomes depressed and the margin in some is slightly raised, round, oval, or slightly irregular, and presents the appearance of a raised seam, along the center of which runs a thin black line. As the patch becomes very slowly larger the base takes on a somewhat atrophic character. In a few of the lesions, especially those on the neck, a number of minute conical elevations are distributed along the ridge, giving it an irregular appearance, and sometimes one or two of these minute cones appear in the central portion of the plaque. The largest patches are about the size of a split pea.

After removing some of the diseased portions with a curette and applying very thoroughly the silver nitrate stick, I have seen on four or five occasions the disease return within a month or two in the manner described, *viz.*: a very minute, dirty brown papule, which, within two or three weeks apparently began to clear up in the center. Other lesions return in the form of a ring or oval ridge. If one of the patches is curetted it is fairly easily removed, but the operation is followed by almost as much bleeding as the removal of a small epithelioma. Examination of the scrapings, either fresh or after treatment with liquor potassæ, is negative. While watching the course of the disease week by week, I have seen new lesions arise which I had not detected the week previous.

One or two of the lesions appeared to have formed round a hair follicle, but others did not exhibit any such relationship.

A histological examination of a large number of sections from the most recent as well as from the oldest patches showed that the

disease consisted of a marked hyperkeratosis of the sweat-pore and duct and of the adjacent hair-follicle. In some of the material excised from the face it was not clear that the hyperkeratosis had commenced in the mouth of the hair-follicle, but in other sections, especially of the smallest variety of lesions, the disease had undoubtedly commenced about the sweat-pore. The oldest lesion, especially from the ear, presented a picture almost identical with that of a mild psorospermiosis follicularis (Darier).

From the clinical and histological characters of the disease there was no doubt of the diagnosis of all the cases, but the special feature of this rare lesion was perhaps most marked in the case of the father of the patient, who presented on the hands lesions which showed the well-defined raised wavy edge with a thin blackish line along the center.

The character of the disease on the hands agreed perfectly with the descriptions of Mibelli and Hutchins. Mibelli has reported six cases, Respighi ten cases, and Hutchins one. I am able to record a group of eleven in one family, which fact seems a first sight to point to a strong hereditary taint. The histological features will be discussed in detail and a clinical description will be given in a later article.

A Universally Adaptable Scale of Measurements for the Accurate and Uniform Description of Cutaneous Lesions.—This paper was presented by Dr. C. W. ALLEN of New York, who first pointed out the desirability of a system of measurement, which could be adopted for all countries. The inaccuracy of description by reference to seeds, grains, nuts, fruits, vegetables, coins, and the like was gone over, and the international confusion often occasioned in important questions was dwelt upon. The scheme proposed took for the unit one-quarter of a millimeter, suggestively called by the reader a *tetmil*, from Greek terms indicating a quarter. The sizes range from one to five hundred, and a series of numbered circles inclosed in the larger circle of the scale show at a glance their relative size. It was suggested to authors to insert the scale in their text-books on dermatology, and that by its use the writer would be saved long descriptions and the reader would soon familiarize himself with the numbers and secure a more adequate idea of the size and form of lesions than by the older method. Scientific accuracy was, however, the desideratum, especially as to the smaller lesions, upon whose exact size a diagnosis often rested. A table of equivalents giving the old terms and their corresponding scale size was incorporated in the paper, based upon actual measurements, and it was thought by the reader that this feature alone, if adopted, would prove of value as giving to the various objects now employed for comparison a definite dimensions based upon the average sizes of objects which often vary greatly in size one with another.

DR. DUHRING: I am interested in this paper for it is a subject of some importance. We have, for many years, been accustomed to speak of and describe the lesions, their size and form, according to well-known custom in vague terms, designating certain seeds and

other articles, fruits and products of nature, merely because those objects convey definite ideas of size and form to the mind. They have been useful, and in fact no other method has been proposed and accepted for the description of the lesions of the skin. They are naturally inaccurate, not desirable it would seem, but they have had and still have their use because they convey a definite idea of what the observer has before him; and that idea is conveyed readily in speech or writing to other persons. The plan proposed by Dr. Allen does not convey any special idea of size and form of a lesion unless one is familiar with his table of sizes. If I understand the scheme proposed, in order to make the sizes intelligible he must first be familiar with the table of sizes itself. One gets no idea of the size of the lesion without familiarity with the table. That is the chief objection to the scheme as I view it. I am, nevertheless, in favor of the measurement of lesions. We have been lax in describing their size. At the same time, since it is a fact that lesions vary in size from day to day, a more or less sliding scale is certainly convenient to describe them. I should like to have the question investigated more fully.

DR. ALLEN: Mr. President:—I think that the scheme here is well-adapted for international use, and I had that in mind in making the measurements readily transferable into Metric System Measurements. The size would be known by the number, without one's having a very perfect familiarity with the scheme. There are many diseases in which the size of the initial lesion has a great importance, and it is with the view of getting at the actual size, and the relative sizes, of these smaller lesions, that we need some much more accurate method of description, and with the table I present, I believe that we will get a very much better idea of these smaller lesions than we can get by referring to them as having a diameter of millimeters, inches, or fractions of an inch, because that conveys to us only an imperfect idea of the surface area. If any one will measure the various seeds, fruits, etc., for himself he will be surprised to see how different the diameters are from what he had supposed.

A Peculiar Affection of the Hair-follicle.—By DR. J. GRINDON of St. Louis.

The affection consists of a chronic inflammation of the hair-follicle characterized by extrusion of a portion of the root-sheath proper *en masse*, which remains threaded over the hair and is carried up with it in its growth, the process being repeated from time to time until successive masses bearing a superficial resemblance to nits are strung along the hair. It is accompanied by slight redness about the mouth of the follicle and results in a curable alopecia.

There are found little grayish-white masses threaded beadwise on the hair. In their size, color, and distribution they are so like the ova of the pediculus capitis that one is almost certain to mistake them for the latter at first sight.

The little masses consist of the cells of both layers of the internal

root-sheath (Huxley's and Henle's) surrounded by a layer of amorphous detritus and sebum.

Besides pediculosis, there are other clinical conditions which superficially simulate this form of folliculitis. Among them are trichorrhexis nodosa, monilethrix, piedra, leptothrix, and a few clinical curiosities such as Hodara's disease, Giovannini's disease, etc.

A Case of Impetigo Herpetiformis.¹—By DR. M. B. HARTZELL of Philadelphia.

The patient was a woman, eighty years of age, unusually vigorous for her years. For several months she had suffered from a pustular eruption characterized by a marked tendency to occur in groups, to form crusted patches surrounded by a border of milium pustules, and to appear in successive outbreaks. There was an eruption coincidently upon the lingual mucous membrane. Septic symptoms, such as chills, fever, diarrhea, occurred in the final stages of the malady which terminated in death three months after its first appearance. An analysis of the more important features of all the cases reported, twenty-one in number, exclusive of his own, was appended.

Impetigo Herpetiformis or Dermatitis Herpetiformis.² Report of a Case, with Colored Drawings and Photomicrographs.

DR. J. A. FORDYCE of New York City reported a case occurring in a man aged sixty-six. The eruption when first seen was nearly universal. It was made up of grouped vesicles and vesico-pustules which became confluent over the legs and arms.

Over the thighs and abdomen large irregularly rounded plaques were seen which extended in a peripheral manner, while slowly clearing in the center.

A new outbreak of lesions was accompanied by an elevation of temperature and intense pruritus. After existing for several weeks the eruption slowly disappeared leaving larger pigmented areas on which new groups of vesico-pustules would appear. Papillomatous lesions developed in both axillary spaces.

A small amount of albumin and some granular casts were found in the urine.

The blood and serum from the vesicles contained a large number of eosinophile cells.

A piece of skin from a recent lesion excised for microscopic examination, showed an acute inflammation of the derma and the presence of vesicles in the deep layers of the epidermis.

The cell exudation contained large numbers of polynuclear leucocytes and numerous eosinophile cells.

The eruption presented certain features pertaining to both impetigo herpetiformis and Duhring's disease, and seemed to justify the view which this writer originally held that they should both be included in the same class.

These two cases were discussed together.

DR. DUHRING: I would like to say a few words about the case which Dr. Hartzell has reported. I would corroborate the reader's de-

¹ Will be published.

² Will be published.

scription of the lesions. As I remember the condition of the skin, what struck me particularly was this: There was notable swelling or edema of the skin, the tissues being considerably thickened; that the edema, while superficial, nevertheless involved a considerable portion of the corium, giving rise to a spongy condition. The skin taken between the fingers was difficult to grasp, and gave the idea of soaked leather, or thick chamois skin. The pustules were grouped. At the same time they were not grouped in a distinctive manner. They were irregularly grouped, so that it was difficult to describe just how they were arranged. They were grouped in twos and threes, here and there, but the whole surface was nevertheless dotted with pustules, some being more prominent than others.

I have found the edematous condition of the skin described also in pemphigus vegetans, and this feature therefore may occur in both diseases. I believe that there is a relation (more so than has heretofore been insisted upon) between these two diseases. In my opinion they have much in common. The case just reported tends to corroborate that view. While there were no symptoms of blebs the condition of the skin otherwise was much like that in some cases of that variety of pemphigus.

A few years ago I had the opportunity of seeing a case in Chicago, and later another in Pennsylvania. Both these cases proved fatal, and they both had that peculiar soaked, velvety condition of the corium, upon which other lesions sprang up, that was present in Dr. Hartzell's case.

I would say also, from my examinations of sections of pemphigus vegetans, and the section in the case presented by Dr. Fordyce, which he showed me, that they possess this common feature. The mucous layer of the epidermis is in a state of active proliferation. The section I saw of Dr. Fordyce's case was strikingly marked in that way. I therefore think that there exists much in common between the case of impetigo herpetiformis brought forward by Dr. Hartzell and the cases of pemphigus vegetans that I have seen.

Concerning the case of Dr. Fordyce, from the series of beautifully colored drawings we have had the opportunity of seeing, it seems to me that the disease must be arranged rather with impetigo herpetiformis than with any other disease. Any one viewing the drawings will observe that there is much in common with some of the reported cases of impetigo herpetiformis. I believe Dr. Fordyce makes an interrogation as to whether his case is impetigo herpetiformis or dermatitis herpetiformis. There are elements of dermatitis herpetiformis about Dr. Fordyce's case, but I think the lesions entitle the case to be grouped with impetigo herpetiformis rather than with dermatitis herpetiformis. Impetigo herpetiformis is a deeper-seated process than dermatitis herpetiformis. I am entirely willing to let the Hebra and Kaposi definition for impetigo herpetiformis stand.

DR. JOHNSTON: Mr. President:—I have seen two cases of impetigo herpetiformis, one a woman about the same age as Dr. Hartzell's patient, and the other a case which was for a long time in the New

York Skin and Cancer Hospital. The latter was a man, as most of the members know, and he died while there under observation. In neither of these cases was there any vegetation present; and in the case of the man so far from the skin having the soft, chamois-leather feeling described by Dr. Duhring, there was a distinct induration not unlike that of scleroderma. In fact, on the fingers, this condition was so marked as to bear close resemblance to Ball's sclerodactylie. The surface was smooth and denuded of epidermis.

With regard to Dr. Fordyce's case, I saw it at the City Hospital, and, I think, as I thought then, that it is one of dermatitis herpetiformis. The lesions, at first pustular, became later in this case vesicular and remained so. That was never the case with the man who died in the hospital. Moreover, the latter never developed any pigmentation, rather a common sequel of dermatitis herpetiformis, as seen in this case. Pruritus is a cardinal symptom in herpetiformis dermatitis; it was not present in the impetigo. As regards eosinophilia in the blood and vesicular contents described by Leredde and Gilchrist, the evidence points toward the same diagnosis, so far as our present knowledge extends. The early lesion in the case is sufficiently illustrated by the microscopical preparations of Dr. Fordyce. It begins in the mucous layer of the epidermis.

DR. HYDE: I may be allowed to say a word. I am impressed with what Dr. Duhring says with reference to the resemblance of impetigo herpetiformis to pemphigus vegetans. There were certain peculiar features in the case seen by us in Milwaukee which I have not seen in impetigo herpetiformis. After the meeting of this Association in which I read a description of this affection, Dr. Zeisler wrote me a note telling me that the description corresponded precisely with the features of the patient first seen by him in Chicago. In this note he called my attention to several points of resemblance. At the same time I think there were marked clinical differences. Dr. Duhring's remarks with reference to the resemblances are important and suggestive.

Respecting the eosinophiles seen in these cases, I am impressed with the fact that they differ in different sections. In the sections of the skin of a patient with dermatitis herpetiformis shown by me here, one can distinguish perhaps in one spot, four or five clustered together in the superficial layers of the skin, and in one or two sections which I do not have with me, they were as abundant as in the tissue examined by the French, who report the presence of eosinophiles in very large numbers.

DR. HARTZELL: I have very little to add except that I would like to say that the grouping of the lesions was most marked in the early stage of the disease; but the most striking feature of it was the zone of miliary pustules around the patches. As the lesions spread, this grouping was lost. The grouping was not circinate in character, but irregular, differing in that respect from the cases reported.

DR. FORDYCE stated that severe forms of dermatitis herpetiformis sometimes presented many features in common with impetigo her-

petiformis. In the case which he reported it was difficult to determine to which class it belonged. The constitutional disturbance, chills, fever, marked impairment of the general health, together with the distinct impetiginous character of certain of the lesions, pointed to impetigo herpetiformis; the multiformity of the lesions, the absence of mucous membrane changes, and the rapidity with which recovery from an attack took place would seem to ally it to Duhring's dermatitis.

The papillomatous condition which the patient presented to such a marked extent has been met with in both of these affections as well as in pemphigus vegetans and certain cases of impetigo contagiosa.

It is quite probable as Herxheimer has pointed out that certain changes in the epidermis may be met with in all these affections which determines the papillary outgrowths.

DR. DUHRING: The observation was made by Dr. Fordyce that scars existed. His experience on that point has been different from mine. I think the term scar or cicatrix would imply a change and loss in the corium. I would not use the term scar unless such lesions existed. In the cases I have met with there has not been any scarring after the disease has disappeared. It is the first intimation that has come to me that any one has seen permanent scars follow dermatitis herpetiformis.

A Case of Pseudo-Lupus Vulgaris due to the Presence and Growth of a Blastomycetes.—By Drs. T. C. GILCHRIST and W. R. STOKES of Baltimore.

The case reported (a preliminary appeared in the *Johns Hopkins Bulletin*, July, 1896) was one of a somewhat extensive cutaneous disease which occurred in a man, thirty-three years of age, who gave the following history: The disease first made its appearance at the back of the left ear, as a pimple, which soon became pustular, eleven and a half years ago. The disease extended forward very slowly and encroached upon almost the entire face, the central portion of which now presented an atrophic scarry condition. Another similar lesion occurred, one month after the primary invasion, on the back of the right hand, which healed in about four years after treatment with caustic; a third lesion appeared on the right side of the scrotum six months after, which increased in size for a year and then healed spontaneously; a fourth inoculation appeared on the anterior surface of the left thigh just above the internal condyle and it grew for a year and healed spontaneously; and a fifth lesion appeared on the back of the neck and it also healed spontaneously after growing for two years. The disease when first examined presented the features of a lupus vulgaris. [A photograph was shown.] There were no enlarged lymphatic glands and the patient's health had always been good. Family and personal history did not reveal any syphilitic or tuberculous taint.

Sections from the cutaneous lesions showed the presence of what appeared to be budding blastomycetes. The sections also presented pathological features similar to those seen in the first case recorded by Gilchrist, and in many sections almost typical tubercles were found.

The organisms in the tissues are chiefly spherical, unicellular bodies, varying from 10 to 20 μ in diameter, and consist of a doubly contoured membrane which encloses a fine granular protoplasm with sometimes a vacuole. Many budding forms in various stages were found. No nucleus could be demonstrated, neither were any mycelium or hyphae present in the tissues. The parasite was almost always found as an extracellular organism only a few comparatively being enclosed in giant cells. Careful search was made for the presence of tubercle bacilli in the tissues but none were found.

Pure cultures were obtained directly from the cutaneous lesions in two places, *viz.*, from the pus squeezed out from between the papillomatous variety of the lesion. The organism grew on all ordinary media, but especially on potato, and a fairly profuse mycelium was produced. Carrying older cultures through generations produce on rare occasions almost practically no mycelium. The parasites differed slightly from those in the tissues and were round, ovoid, doubly contoured, refractive bodies, varying in size from about 10 to 20 μ in diameter. The mycelium was, on rare occasions, of two varieties, very fine and also coarse, with sessile buds, sterigmata and conidia. We have given a table of our inoculation experiments so that one can see at a glance how the organism was pathogenic in guinea-pigs, dogs, a sheep, and a horse, and nonpathogenic in mice, and, in one case, rabbits.

In the tissues of none of the animals successfully inoculated was any mycelium found.

Since our organism did not ferment glucose, lactose, or saccharose, and produced profuse mycelium it may either belong to the blastomycetes or to the oidia, but we are inclined to regard it as a blastomycetes.

We therefore consider this case to be one of a pure local blastomycetic dermatitis, which is the second to go on record, Gilchrist's being the first.

DR. ALLEN: I feel that we can congratulate ourselves again on having in the Association a man who can, and will, do this kind of work with such earnestness and such results. I congratulate the reader upon the vast amount of work that he, and his collaborator, have gone through with, and upon the results so far obtained. I was pleased yesterday to see the demonstration of the organisms under the microscope, and the subject furnishes altogether a very interesting study.

DR. FORDYCE stated that the paper was one of the most important presented before the Association and should serve to make us all careful in our diagnosis of tuberculosis of the skin.

He had lately had a case of chronic ulceration of the scalp under his care in which syphilis was excluded by treatment, and many features of tuberculosis were absent. He thought the disease might prove to be one of blastomycetic dermatitis and would, at his first opportunity, endeavor to find the fungi described by Dr. Gilchrist.

DR. DUHRING: I have listened with interest and pleasure to this

THE CASE.

Two pure cultures from pus of the case.

| (d) | (b) | (c) | (d) | (e) | (f) |
|--|--|---|--|--|--|
| Fresh tissue injected subcutaneously into a white mouse. Died in 3 days—pneumococcus septicaemia. | (1) Guinea-pig, subcutaneously into a guinea-pig. Results nil. | (2) Guinea-pig, intraperitoneal. Killed in 2 months. Results nil. | (3) Guinea-pig, subcutaneously into 2 guinea-pigs. Killed in 2 months. Results nil. | (4) Culture injected subcutaneously and by scarifying dog. Results 1, except a local abscess with pus organisms. | Dog I. Pure culture injected intravenous into external jugular vein. Running from the nose. Killed in 2 months. Pseudotuberculosis of lungs and enlarged bronchial glands. |
| (1) Pure culture inoculated intravenously into a sheep. Killed in 2 months. Pseudotuberculosis in the nodules. | (2) Pure culture inoculated subcutaneously into a horse. Abscess, at local inoculation. Pus injected intraperitoneal. Guinea-pig results nil. Sent when injected subcutaneously. | (3) Pure culture inoculated into guinea-pig intraperitoneal. Killed in 2 months. Localized peritonitis, chronic abscess, large, penicillated, contained thick creamy pus and large number of organisms. | (4) Cultures in bouillon injected into mesenteric vein of guinea-pig. Killed in 2 months. Pseudotuberculosis lungs. Nodules contained the parasites. | (5) Pure culture inoculated intravenously into sheep. Killed in 2 months. Pseudotuberculosis lungs. Abscess of epididymis contained large number of organisms. | Two c.c. of a teased nodule in bouillon injected intravenously into dog II. Killed in 2 months. Pseudotuberculosis in both lungs. |
| Nodule teased injected intraperitoneal into guinea-pig. Killed in 2 months. Results nil. | Pure culture from the pus. | Pure culture. | Nodule teased injected intraperitoneal into guinea-pig. Killed in 2 months. Results nil. | Nodule teased injected intraperitoneal into guinea-pig. Killed in 2 months. Results nil. | Nodule teased injected intraperitoneal into guinea-pig. Killed in 2 months. Results nil. |
| In 2 months abscess between abdominal wall and intestines. | Cultures pure from the pus. | Killed in 2 months. Pseudotuberculosis in both lungs. | Nodule teased and injected intraperitoneal into guinea-pig. | Killed in 2 months. Results nil. | Killed in 2 months. Results nil. |

excellent piece of work brought before the Association by the reader of the paper.

In viewing the photograph of this case, I was immediately struck with the likeness to another case, three photographs taken at different periods of which I have had opportunities of seeing. It was under the care of Dr. Morrow, who made the diagnosis of tuberculosis of the skin. Clinically it did not resemble lupus vulgaris. Dr. Morrow assured me that the case was undoubtedly tuberculosis. I would say that the photograph which Dr. Gilchrist has shown is so much like the one in Dr. Morrow's case that I could hardly distinguish one photograph from the other. Clinically they would seem to be one and the same disease. The photograph of Dr. Gilchrist's case, shows a form of disease that some of us from a clinical standpoint would regard as tuberculosis cutis, some possibly scrofulosis cutis, others as lupus vulgaris.

DR. WHITE said that he did not think that the reader had shown that this affection was not possibly a secondary inoculation upon a preceding tuberculosis of the skin.

DR. HYDE: I take pleasure in congratulating the reader on the contribution he has made to our knowledge of the subject. It will make us exceedingly careful in the future when in the face of certain forms of tuberculosis. I think I have seen this disease before. Dr. Duhring also recalls such a case. But reviewing the cases of tuberculosis of the skin which I have seen, I do not recall any one having exactly the features seen in this case, and certainly no instance in which tuberculosis of the skin of the hands coexisted with face lesions. I presume that the disease in Dr. Gilchrist's case was auto-infective and the one region was attacked after the other.

With reference to what our president says about the rarity of verrucous tuberculosis upon the foot, some of the members present may remember that I showed a portrait of one of these cases in London last year, illustrating my paper for the International Congress, on the "Relations of Tuberculosis to Diseases of the Skin other than Lupus Vulgaris." A patch was shown low down on the instep of an adult.

DR. BOWEN said that he thought Dr. Gilchrist had given rather too narrow a description of tuberculosis verrucosa cutis. Since our knowledge of this form had become wider, we had found that the original description of Riehl and Paltauf was hardly broad enough, as cases occurred where there were no zones, or even any pustules, but a dry warty formation solely, from the beginning. He also considered that this form might appear on many different regions of the body, and he had in mind two or three cases where there were large plaques on the buttocks. He considered Dr. Gilchrist's paper a distinct contribution to dermatology.

DR. W. T. CORLETT of Cleveland: Two papers, "Notes on the Status of Colles' Law;"¹ "A Case of Spontaneous Gangrene of the Skin."² Read by title.

¹ JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES, June, 1897.

² Will be published.

DR. W. A. HARDAWAY of St. Louis: A paper, "Some Further Observations on Electrolysis in Diseases of the Skin."¹ Read by title.

DR. J. C. WHITE of Boston presented a paper, entitled "Lymphangioma of Labia Majora."

The following officers were elected for the ensuing year: President, Dr. J. N. Hyde of Chicago; vice-president, Dr. E. B. Bronson of New York; secretary and treasurer, Dr. I. T. Bowen of Boston.

Therapeutic Notes.

New Formulæ.—HERBERT SKINNER (*Brit. Journ. of Derm.*, February, 1897, p. 68).

Unna's Gelanthum, a watery varnish for the treatment of eczema, may be written in prescription form as follows:

| | | | | | | | | | | |
|---|-----------------|---|---|---|---|---|---|---|---|---------|
| R | Gum Tragacanth, | . | . | . | . | . | . | . | . | 3 ii ss |
| | Gelatin, Opt., | . | . | . | . | . | . | . | . | 3 ii |
| | Glycerin, | . | . | . | . | . | . | . | . | 3 vi |
| | Thymol, | . | . | . | . | . | . | . | . | gr ¼ |
| | Aqua Dest., | . | . | . | . | . | . | . | . | q. s. |

Place the tragacanth and gelatin each in ten ounces of water, in covered jars, and make up the final quantity with water to twelve ounces. It yields a semi-liquid preparation, which may be combined with resorcin, naphthol, salicylic acid, calamine, etc. It dries in two to ten minutes.

An ointment base described as easily absorbable, readily applied, aseptic, and not too greasy, consists of:

| | | | | | | | | | | |
|---------------|---|---|---|---|---|---|---|---|---|------|
| Lanolin, | . | . | . | . | . | . | . | . | . | 3 iv |
| Vaselin, | . | . | . | . | . | . | . | . | . | ii |
| Lanolin Soap, | . | . | . | . | . | . | . | . | . | iv |
| Aq. Rosæ, | . | . | . | . | . | . | . | . | . | iv |

Dissolve soap in the rose water, melt the two other ingredients, stir in the solution until mixture is cold. More than half an ounce of spirit and acids are not compatible.

Lanolin will mix with its own weight of extract of quillaia, forming a cream which is miscible with water or alcohol in any proportion; substituting for the extract a solution (gr. i, 3 i) of saponin in water and a few drops of alcohol, a creamy liquid is obtained, which holds other substances in suspension, and can be applied as a liquid. In hard, fissured skin, the author recommends the following:

| | | | | | | | | | | |
|---|-----------------------------|---|----|---|---|---|---|---|---|-------|
| R | Emol. Keleet, | . | . | . | . | . | . | . | . | 3 ii |
| | Zinci Ox., | . | . | . | . | . | . | . | . | 3 i |
| | Glycerin, Plumb. Subacetat, | . | . | . | . | . | . | . | . | q. s. |
| | Lanolin, | { | aa | . | . | . | . | . | . | 3 ss |
| | Vaselin, | } | | . | . | . | . | . | . | |

¹ Will be published in forthcoming number.

It has a softening effect and may be combined with a neutral soap, when it becomes soothing and emollient.

Applications in Scborrhea Capitis.—For cleansing the scalp this formula is recommended:

| | | |
|---|-----------------------------|-------|
| ℞ | Sapo. cast. alb., | ℥ i |
| | Spts. vini rect., | ℥ i |
| | Ether, | ℥ ii |
| | Aq., | ℥ iii |

Dissolve the soap in water, add the spirit, clarify by filtration through kaolin, and add the ether. Even mercuric chlorid can be added to this. A shampoo liquid containing carbonate of ammonium with borax is as effective as potash or soda soaps, and less caustic.

| | | |
|---|-----------------------------|------|
| ℞ | Ammon. Carbonat., | ℥ ss |
| | Boracis, | ℥ i |
| | Aq. Dest., | O j |
| | Dissolve; add: | |
| | Glycerin, | ℥ iv |
| | Bay Rum | O j |

A new formula, with saponin, is sweeter, antiseptic, and an improvement:

| | | |
|---|----------------------------------|--------|
| ℞ | Saponin, | gr. xx |
| | Tinct. Benzoin, | ℥ i |
| | Aq. Dest., | ℥ ss |
| | Glycerin, Ac. Carbol., | ℥ i |
| | Aq. Colon., | ad ℥ i |

These two "hair tonics" have much to recommend them, the first for its lack of alkalinity and bleaching tendency, the second for its combination of oil with alcohol.

(1)

| | | |
|-----|-----------------------------|-----------|
| ℞ | Quin. Sulph., | gr. xx |
| | Ac. Sulph., dil., | q. s. |
| | Tinct. Canthar., | ℥ i |
| | Hazeln., | ℥ ii |
| | Glycerin, | ℥ i |
| Aq. | Flor. Aurant., | ad ℥ viii |

(2)

| | | |
|---|---|--------|
| ℞ | Tinct. Canthar., | ℥ xiv |
| | Tinct. Cinchon, | ℥ ii |
| | Tinct. Benzoin, | ℥ vi |
| | Spts. Lavand., | ℥ iss |
| | Ol. Ricini, | ℥ ii |
| | Alcohol, | ad ℥ x |
| | Dissolve oil in alcohol, and add other ingredients. | |

After a vigorous application, all excess should be dried off with a towel.

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Original Communications.

SOME FURTHER OBSERVATIONS ON ELECTROLYSIS IN DISEASES OF THE SKIN.

By W. A. HARDAWAY, M.D.,
St. Louis, Mo.

IT is now about twenty-four years since I began the systematic use of electrolysis in the treatment of diseases and deformities of the skin, and it is doubtless with equal satisfaction that the other pioneers in this method observe that it has found a permanent place among the recognized agents at our command, even if we are obliged to abate, here and there, some of the more extravagant claims made in its behalf. If the title of this paper suggests that I have anything essentially new to report in the nature of other conquests for electrolysis I must ask you to dismiss the idea.

I wish merely, in the first place, to go over the old ground briefly, and, secondly, to call attention to certain points in the technic of the operation that are often overlooked.

I think it may be said that electrolysis found its limit of application (in the skin diseases) almost from the first year of its use, and I daresay that its various methods of employment, advocated from time to time in the medical press, had already been tried quite early by those familiar with the subject.

From a consideration of the nature of this agent and its mode of action, it may be claimed for it, that where thorough superficial destruction is required, and this with a minimum of local disturbance, subsequent scarring, and relatively slight pain, there is nothing comparable to it; and, therefore, its range of usefulness is easily understood and as readily utilized.

It will not be necessary for me to go over old and familiar ground; the great value of electrolysis in hypertrichosis, for telangiectasis, for milia, moles, warts, and small tumors of all sorts, will probably be admitted by every one. The fact that scarring is either entirely absent, that is, practically, or very slight, provided the operation is properly done, is the great recommendation of this agent in the field of cosmetic surgery.

In an excellent and very practical paper on electrolysis in skin diseases written by Dr. Bowen in 1892, the author agrees in the main with what has been claimed for this method, but, in common with other observers, he very naturally has some doubts as to its efficacy in keloid, and gives but a partial assent to its asserted value in port-wine mark.

As regards keloid I am about in the position that I was in 1886. I then stated that I had removed a small keloid under several applications of electrolysis, and that in view of the intractable nature of the affection I felt justified in reporting even so slight an achievement.

Since then I have sometimes succeeded, and perhaps more often failed, but I have confined the operation to small growths only. The large, well-developed, or multiple keloids I have not attempted for obvious reasons. I still regard electrolysis as well adapted for bettering the appearance of unsightly hypertrophied scars.

In telangiectasia certain kinds of vascular nævi, the so-called spider cancer, etc., there is no better and more satisfactory agent in the hands of a judicious operator, but taking the port-wine mark as a whole the method has not met with the success that I had originally anticipated from it. Still, in some cases I have certainly succeeded in ameliorating the deformity, and in others the results have been brilliant beyond expectation. My experience teaches me that the best success is obtained, as would be expected, in the superficial cases, while in those instances of the affection where the lesion consists of a dense network of spongy vascular tissue we can hope for little. Of course, it is nearly always possible to substitute a white mark for a red one, but that is not the object in view.

While not bearing directly upon the point under discussion, I may be pardoned for relating the following case, which illustrates besides a certain type of conditions for which electrolysis is thoroughly adapted. Some years ago a young married woman fell from a bicycle and received a sharp blow over the right malar prominence, which eventually resulted in a dark brown somewhat thickened lesion about the size of a half-dollar. Over this whole area coursed innu-

merable blood-vessels, and the combination of brown and red produced a most striking deformity. At the conclusion of a half-dozen or more sittings the vessels were completely obliterated, the pigmentation disappeared, and it is to-day impossible to determine the exact seat of the injury.

Although it is fully twenty years since I first made use of electrolysis in lupus vulgaris, mention of which fact is made in my various contributions and in my "*Manual of Skin Diseases*," the opportunities of seeing cases of that disease are so infrequent in St. Louis my experience is necessarily limited. Later writers, as, for example, Jackson and Ravogli, have reported favorably on the method; indeed, the last-mentioned observer is very enthusiastic in its praises in selected cases.

I believe that for small foci of lupus, and as a treatment for separate nodules, and especially relapsing tubercles, it is superior to the mechanical and caustic methods most in vogue. For large areas of infiltration with ulceration it is tedious and inferior to the other measures. The Gärtner-Lustgarten plan with the silver plate, or disk, I have never tried.

In tuberculous infiltration of the skin, other than lupus vulgaris, I regard electrolysis most favorably. In a case reported by me to this Society in 1893, in which the skin of the face was affected by a tuberculous process resembling lupus erythematosus, nothing succeeded so well as electrolysis. Some few months since I saw this patient again and found the lesions electrolytically destroyed were permanently cured, whereas other places treated by resorcin, pyrogallol, curettage, etc., were still in existence, either never having been adequately destroyed, or had suffered relapse.

Although I have long advocated the use of electrolysis in lupus erythematosus I do not advise it in acute or superficial forms of the disease; but in chronic patches with much thickening it has been of great advantage in my hands. It is especially in those types of disease called by Brocq "*lupus erythémateux fixe*," which are undoubtedly tuberculous, and perhaps because they are tuberculous, that electrolysis acts so well. One of the first cases of this sort in which I tried electrolysis was referred to me by Dr. J. C. White, a good many years ago. The patient lived in St. Louis and had been under the care of his family physician for a long time for a presumed epithelioma. Finally, becoming dissatisfied he went to Boston to see Dr. White, who made a diagnosis of lupus erythematosus, and kindly advised the gentleman to see me on his return home. The patient had a long infiltrated patch on his left cheek over the parotid region,

and a similar small patch over the bridge of the nose. There were no lesions on the scalp or ears, nor was the disease in any way symmetrical.

The disorder was attacked electrolytically, and although the treatment was tedious, the result was eminently satisfactory, and, moreover, has been permanent. I really believe that this case was not a lupus erythematosus at all, but a form of tuberculosis cutis; at any rate, it is in just such cases that electrolysis acts best.

Small epitheliomata may undoubtedly be cured by electrolysis, but it is advisable to attack the skin deeply and for a considerable area beyond the apparent line of infiltration; and so little scar is left after this procedure the operator is justified in proceeding boldly and with a free hand. I have sometimes combined electrolysis with curettage and the subsequent application of fused chromic acid. In such instances, however, the only advantage, if any, over an arsenious acid paste, is the shorter duration of the pain.

In conclusion, I wish to add a few words on the technic of electrolytic operations, because both in conversation with physicians and from reading certain communications in the medical press, I still find much misunderstanding as to the best mode of procedure.

It is happily true that the former common mistake of confounding electrolysis with the electrocautery is rarer than in former years, but it is not uncommon to meet with the statement that the operation is unusually painful, or to see for oneself that unnecessary destruction of tissue has followed upon an operation that was perhaps meant to secure a cosmetic result.

As regards pain, which at any rate from the patient's standpoint is of some importance, the amount of it may be considerably lessened by the simple expedient of making the current after the needle has been inserted, and when the necessary electrolysis has been accomplished by directing the patient to release the positive electrode before the needle is withdrawn; in other words, exactly reversing the initial steps.

Of course this is nothing new to the experienced electrician, but it is astonishing how often these simple manipulations are neglected by the general practitioner. It is a daily experience to have patients come to me with a dread of electrolysis acquired in some former operation, and then to witness their delight at what seems to them a relatively painless affair. Sometimes even good authorities are careless in their observance of these elementary rules. For example, a gentleman highly accomplished as a dermatologist, writing in one of our special journals on the treatment of a certain case, states

that the positive pole, consisting of a pad soaked in salt water, was "fixed to one arm." The success of the treatment was perfect, but I fancy the patient must have suffered a good deal of unnecessary pain.

I have long since discarded the positive sponge electrode—which even when I used it I never allowed the patient to grasp but merely to touch with the finger tips. I now always place the positive pole electrode in a small bowl or tumbler of water, and the connection is established by inserting one, two, or three fingers, as may be required. This method has decided advantages, which, it occurs to me, are obvious enough without further comment.

When thorough radical destruction of tissue is demanded the amount of resulting scar is not of much moment, although it is remarkable what thin and pliant cicatrices follow electrolysis, but in the small cosmetic operations about the face the usual mistake made is in the endeavor to do too much at one time.

On the contrary, it is always advisable to do very little at a time, and in the case of small growths no effort should be made to pass the needle under the growth, but, gradually, at successive sittings, to reduce the lesion to the level of the skin. Finally, after some weeks' rest, when the result of the previous operations can be estimated, there are usually ridges and irregularities to be smoothed down. It will be found that the result justifies the pains.

It is a matter often disregarded, but even these trifling operations should be done under the strictest antiseptic precautions.

Immediately after an electrolysis the parts should be fomented for five or ten minutes with very hot water, and this procedure should be repeated at least twice on the same day, but not afterward. In this way the redness and tumefaction are at once allayed, and subsequent inflammatory changes are largely prevented.

As a rule, after the first day no other applications or dressings are required.

A REPORT OF THE VALUE OF FORT'S METHOD OF ELECTROLYSIS IN THE TREATMENT OF SEVERE STRICTURES OF THE DEEP URETHRA, WITH THE PRESENTATION OF A NEW INSTRUMENT FOR ITS APPLICATION.¹

By GRANVILLE MAC GOWAN, M.D.,

Professor of Diseases of the Skin and Genito-Urinary Organs in the University of Southern California.

IN the consideration of the value of any treatment proposed for the cure or amelioration of the condition of stricture of the male urethra, several factors must be taken account of.

Whatever treatment is inaugurated should be, so far as possible, devoid of danger to the life of the individual, while affording him relief, either temporary or permanent, from the principal annoyances incident to his pathological condition.

Strictures are cut within the channel of the urethra by instruments devised so that the cutting may be done from before backward, as in the Maisonneuve type, or from behind forward, as in the Otis type. Strictures are rapidly divulsed or dilated. They are incised from the outside when no passage can be secured for a cutting instrument within the urethra, or when, in the judgment of the operator, cutting within the urethra is either too dangerous or likely to prove, from the character of the stricture, inefficient.

All of these operations have for their end the enlarging of the narrowed urethra to such a caliber that the contents of the bladder may be discharged with reasonable muscular effort by that viscus. For, as Guyon pertinently remarks, "We piss with the bladder, and not with the urethra." Any surgeon who has had a large, prolonged, and varied experience with stricture of the urethra is not a constant advocate of any particular one of these methods. It sometimes happens that the cicatricial changes which have taken place within the tissues of the spongy body are so extensive that the exploring instrument shows many encroachments upon the caliber of the tube of different sizes, which give a sensation of roughness to the feel of the urethra over perhaps the greater portion of its extent, simulating very much the surface of a washboard.

It is common for surgeons who describe, or who attempt the description of such a urethra, to speak of its containing three, four,

¹ Read before the Medical Society of the State of California at its meeting in San Francisco, April 22, 1897.

five, six, or more strictures. In these cases the cicatricial condition of the urethra is rather a general one, with intervals of lessened density of fibrous tissue, than distinctly localized narrowings due to isolated inflammatory products.

In these atrophic urethras we may never hope by any operation for an exact cure, but are fortunate when we can secure and maintain a caliber sufficiently large to drain the urinary organs with enough of freedom to prevent the changes in the urethra, bladder, and kidneys which follow backward pressure. In these conditions it is best that we remain satisfied when we restore moderate distensibility with its accompanying relief.

This accounts for the teachings of Ultzman and Guyon that a caliber of 26 F. is a large enough urethra to secure for old cases of stricture, and is really the reason they have not attempted to reach higher calibers during operations.

When strictures are situated within the area of the phallic portion of the spongy body, and are not dilatable, or are irritable, I believe, if any instrument may be passed through them, that the operation of choice is internal urethrotomy, and the instrument I prefer is one of the Maisonneuve pattern.

When the seat of the stricture is posterior to the penoscrotal junction, we enter a region where internal cutting operations become dangerous, the danger increasing with the depth of the stricture. I do not think Fenwick exaggerates its risk, for beneath the arch of the pubes, with the plexus of Santorini above and the artery of the bulb below, the man who frequently performs an internal cutting operation must sooner or later have the misfortune to have a patient bleed to death. It is in this part of the urethra also that the greatest dangers of the formation of false passages exist; and that it is most difficult to secure and maintain a caliber which will permit at all times of the passage of a fair-sized instrument from without, and the passage of a similar stream of urine from within. For such strictures my experience leads me to favor the operation of electrolysis by the method of Fort, and I have the pleasure of presenting to you some cases bearing upon its value to-day.

I do not advocate this method exclusively for the treatment of tight strictures in the bulbo-membranous urethra, for, since becoming familiar with its use, I have found several cases where this instrument could be passed which eventually, by reason of the warty nature of the walls of the urethra at the position of the stricture, required external urethrotomy and careful trimming of these excrescences from the surface of the mucous membrane by delicate curved

scissors before the obstructive condition could be permanently relieved.

Under the advantages of this modified Fort electrolyzer, which, as you will observe, is much like a Maisonneuve urethrotome, with a flat, triangular, blunt knife of platinum substituted for the steel blade, the shaft of copper being covered with baked hard rubber, channeled at the distal end for threading upon a whalebone filiform guide. The operation does not necessarily require general anesthesia, and frequently we may dispense with even local anesthesia. There is very little or no bleeding. If antiseptic precautions are observed in the course of the operation, the urethra well washed with solution of silver nitrate 1 to 5000, or Thiersch solution, both before and after the operation, there is no danger of urethral fever. The operation is a speedy one, and the results are equally good with those secured by the much more dangerous cutting operations. These things being true, you will certainly agree with me that in many cases of dense undilatable stricture of the deep urethra it is the operation of choice. In timid individuals with tight strictures, having a dread of cutting operations, it is available; but for such cases, in stricture of the anterior urethra, I would advocate the use of larger blades.

In the use of the instrument the same care is to be observed to be sure that the guide has entered the bladder that is required in the use of a Maisonneuve. Care must be taken not to use the electrolyzer after its point has entered the bulb, as a lever of the first class, for in the rotten tissues in the neighborhood of a stricture, or in a tuberculous urethra, the point may be readily made to penetrate the walls and a false passage created. It is better in purchasing to secure an instrument channeled at the point sufficiently large to allow of its being threaded upon one of the ordinary whalebone filiform guides of commerce. The original instrument made for me gave me great annoyance in this respect, for there were but two filiforms in my case upon which it could be threaded, and of course you all know that in packing a urethra with filiforms, in front of a stricture, you have no means of choosing the particular filiform which will eventually pass through its channel, and you had better have an instrument that can be threaded upon the one which does.

In Cases VIII. and X., strictures of the warty type, I could not succeed, after many attempts at different times, in passing a filiform. Finally I got one through the stricture by threading it upon a No. 8 F. tunneled silver catheter. When safely within the bladder, the catheter was passed forward, releasing the filiform, and with-

drawn, leaving the filiform still in the bladder. Upon this the electrolyzer was threaded and the operation speedily finished. I have had an electrolyzer made with the blade upon the convex side for cutting upon the floor of the urethra, as it sometimes happens that the obstruction is upon the floor entirely or principally. I found this instrument very useful in cases No. II. and No. X.

The mode of action of this instrument is not by heat, for the platinum remains cool during the whole of the operation. The tissues above the blade are dissolved, hydrogen and caustic potash being given off by this, the negative electrode of the battery, during the process of the dissolution, and the blade thus ploughs, rather than cuts, a way for itself through the cicatricial mass. Its action is confined to the narrow compass of its apex, and the result is a linear scar, similar to, but I believe more flexible than, that made by the keen-edged cutting blade of the Maisonneuve.

The current required for the operation is furnished by a six-cell galvanic battery, capacity of six volts, or by a storage battery of a similar capacity containing a resistance coil, the strength of current registered by a McIntosh milliamperemeter being 3 to 15 milliamperes. Care must be taken that the knife is connected with the negative pole, and not with the positive.

A large, flat, clay electrode, or a large wire-gauze electrode covered with from twelve to fifteen layers of cheese-cloth, soaked in a solution of common salt, is applied to the abdomen and connected with the positive pole of the battery. The time required for the electrolyzing of a stricture by this method depends upon the strength of the galvanic current, the density of the stricture, and its length. In my experience it has varied from half a minute to forty-five minutes, the longest periods being those of Case No. I., in which the stricture extended from the meatus to the apex of the prostate and was through tissue that was covered with phosphatic deposits, and in Case No. X., an unusually hard old stricture.

The original instrument of Professor Fort, which, through the kindness of Dr. Bazet, I am enabled to show you, was made from a French elastic catheter, with filiform attachment of the same material. Into this catheter on one side the triangular platinum knife is set, the electric wire furnishing it with a current being passed through the hollow portion of the instrument. An illustration of this instrument may be found in the article by Fort in the *New York Medical Journal*, November 26, 1895. The improved instrument which I present to you was made for me by Geo. Tiemann & Co. of New York City, from rather firm copper wire, to which the platinum

blade is soldered, and over which is placed skilfully a covering of baked hard rubber. The shaft of the instrument has a caliber of No. 11 F. The knife cuts to 26 F.

Most usually, immediately after the operation, in dense strictures, a full-sized steel sound cannot be passed, a 20, 21, or 22 passing easily, but a 23, 24, or 25 either with great difficulty or not at all. But after an interval of twenty-four or forty-eight hours the full-sized sound can be passed, and by patient effort the stricture may be dilated to a higher degree.

I do not find that deep-seated strictures treated by this method show as much tendency to contract as those treated by internal urethrotomy.

In fact, in Case No. IX. the difference between the ultimate cicatrix caused by internal urethrotomy and this method of electrolysis is very well shown. The cut made is a linear one, and the scar left is of the same character, as I had occasion to see in the *post-mortem*

FIG. 1.



examination of Case No. IV. The result is the splice spoken of by Bryson in the roof or the floor of the urethra as the process of electrolysis has been conducted.

The cases selected for this report have been difficult and severe ones. The result in Case No. X., while satisfactory to the individual, is not satisfactory to me, for I have not been able to maintain a greater caliber than 18 F., and as the face of the stricture is covered with vegetations and the bulbous urethra channeled with false passages, the result of awkward or incompetent instrumentation, I believe that eventually, to secure thoroughly satisfactory results, a Wheelhouse operation, with the trimming away of the excrescences upon the mucous membrane of the urethra, will be necessary.

CASE No. I.—J. B., farmer, sixty-three years old, physical power good, sleeps and eats well, smokes much, and is a confirmed brandy drinker. He had the clap thirty-five years ago, and following it inflammation of the prostate and bladder. The disease lasted two years.

On January 1, 1896, a stone left the bladder and lodged in the perineal urethra. The obstruction to the flow of urine was not complete. By working at it, after a number of days he broke it and forced the larger fragment to the penoscrotal junction. Here his resources failed him. A medical attendant, by combined outside pressure and the internal use of long dressing-forceps, succeeded in crushing and forcibly withdrawing this portion of the stone. The urethra was greatly lacerated and gradually closed.

When he was brought to me, April 6, 1896, he was dribbling, but passed voluntarily, five or six times a day, under much straining and in a fine stream, a certain quantity of acid, purulent urine containing a moderate amount of pressure-albumen. From the posterior third of the perineum forward to the penoscrotal junction, the urethra could be felt as a nodular cicatrix, and the spongy body of the phallic urethra to the glans was dense and gristle-like. The straining had produced double inguinal hernia.

On April 7th he was given an anesthetic, and an unsuccessful effort made to pass an instrument. The inner surface of the urethra was so covered with phosphatic deposits and impacted gravel that the finer silk and linen, and even the whalebone guides used, were destroyed. The caliber of the channel was so small that glycerin or warm oil could not be injected.

On April 9th the urethra was opened at the apex of the prostate without a guide. The stricture was found to include the membranous urethra, and no instrument could be passed from behind forward. The other fragment of stone was found at the place of incision and removed. No stones were found in the bladder.

On April 25th the patient, being in excellent general condition, was once more anesthetized, and this time, the congestion of the urethral tissues having subsided, by patient manipulation I succeeded in passing my finest whalebone guide from the meatus to the wound in the perineum. Upon it the electrolyzer was threaded, and in twenty-five minutes I had reestablished the urethral channel. A No. 18 F. silk catheter was passed to the bladder and tied in. In time the urethra scaled its surface and became free of gritty particles. In two months the perineal wound closed; a smooth channel of a caliber of No. 20 F. remained, requiring the occasional passage of a steel sound, but serving very well for urination. There was no bleeding at the time of the operation, and no fever following it. The result seems permanent, for he now, one year afterward, continues to urinate freely through the channel I made for him.

CASE No. II.—September 2, 1896, H. B., forty-two years old,

American, an officer of the peace, and a man of dissolute habits. He has had the clap numerous times; first, when about eighteen years old. Is now suffering from gonorrheal rheumatism, and has a urethral discharge containing gonococci. Stricture of the bulbomembranous urethra five and a half inches from meatus caliber No. 7 F., dense and irritable. His physician has patiently tried dilation for a number of months, but without benefit. He was anesthetized, the urethra irrigated with Thiersch solution, and a filiform passed to the bladder, the electrolyzing knife threaded on it, and the operation completed in ten minutes. Immediately afterward only a No. 20 F. steel sound could be passed, but in four days a No. 27 F. passed easily. In two weeks the rheumatism had disappeared, all discharge ceased, and urination was easy. He was given a No. 27 F. sound to pass twice a month himself, and at the time of the writing of this article remains free of any annoyance from his stricture.

CASE NO. III.—September 15, 1896, G. K., thirty years old, cook, general habits good; suffers much from gastritis. Urine normal. He had gonorrhea six years ago, and it lasted three months. When he has attacks of gastritis he suffers from retention of urine, requiring catheterization. Stricture five inches from meatus 14 F., dense and resilient, electrolyzed without an anesthetic. Time, seven minutes. Length of stricture, one inch. Immediately afterward a steel sound No. 25 F. could be passed. This case, during the intervals when he was free from gastritis, after the operation, could urinate freely, but during an attack of gastritis he required catheterization the same as before. No hemorrhage, no fever, following operation.

CASE NO. IV.—August 5, 1896, T. M., twenty-two years old, a farmer of good habits. About seven or eight years ago he noticed that he had to rise two or three times each night to urinate. The calls have gradually increased, until now he has to get up every twenty or thirty minutes for this purpose. The call is imperious. With all this frequency there has never been any pain. About three years ago he noticed blood in the last drops of urine. This condition has continued ever since. All the penile and bulbous urethra is roughened and indurated. The prostate is nodular, seminal vesicles enlarged, and the bladder small and contracted. Urine, acid and contains a great amount of pus with some tubercle bacilli. The obstruction to the flow of urine is so great that some kind of mechanical interference is required for relief. It is recognized that no surgical operation can be of any permanent benefit to him. A dilating operation was practically impossible, and a cutting operation was

not to be thought of. So electrolysis was decided upon. It was difficult to pass a filiform to the bladder, on account of the ulcerated condition of the urethra about the stricture in the membranous portion, though a No. 10 F. silk bougie could be very easily passed. During the operation too much pressure was exerted by the hand upon the electrolyzer, and the point of the instrument left the channel about the middle of the bulb and made for itself a false passage beneath the floor of the urethra, about an inch and a half long. This was noticed, the instrument withdrawn from it, and the channel entered again. It was then made to cut its way nearly to the bladder. Relief from urinary strain was the result of this procedure. Two weeks afterward he died from general tuberculosis. At the *post-mortem* all of his organs were found to be tubercular. The prostate, the spongy body, the cavernous bodies, and the walls of the bladder were full of interstitial tubercular abscesses. On the roof of the urethra was found a small, reddish line, indicating the point of absorption of the strictured tissue by the electrolyzer.

I am sure that the operation was a benefit to this individual, for he urinated very freely during the short period of his life following it.

These cases of tubercle of the urethra causing stricture are difficult to deal with. They will not dilate and they may not be cut; and in Fort's method of electrolysis we have a means for securing greater relief than may be obtained in any other way.

CASE NO. V.—October 15, 1896, S. P., laborer, aged thirty-four years, negro. He has had gonorrhea five or six times. Operated upon by me four weeks ago for perineal abscess. Nearly all of the urine passed for two weeks through the incision.

On October 1st, after the subsidence of the inflammatory induration of the perineum, I electrolyzed a dense stricture No. 8 F. one inch in length, situated in the bulbomembranous urethra. In this case the electrolyzer was passed above a small flexible 5 F. bougie previously passed through the stricture. Time of operation, ten minutes. No bleeding, no chill or fever following it. He was discharged from the hospital two weeks from the day of operation, urinating freely. The perineal wound was completely closed. He was given a No. 27 F. steel sound to pass once a week.

CASE NO. VI.—October 26, 1896, Charles L., age forty-nine, German, bartender, habits bad. He denies ever having had gonorrhea and does not remember ever having received any mechanical injury to the urethra; has great difficulty in urinating. Two years ago, while he was working in the lumber fields, following exposure to

cold, he had retention of urine, requiring catheterization, which had to be continued for two months. He then changed his residence, and apparently became quite well. Months afterward he noticed that he had difficulty in urinating, with pain in the deep urethra, and that strain was necessary when he desired to pass his water.

Present condition, moderately dense stricture of the bulb passable only by a filiform. Operation by Fort's method of electrolysis. Time required, twelve minutes. A steel sound No. 24 F. passed immediately afterward. This operation was accompanied by hemorrhage; probably a half-ounce of blood was lost. No pain, no fever, following the operation. Passed out of my care two weeks afterward, and was taking at that time a No. 25 F. sound.

CASE NO. VII.—F. W., age twenty-five, carriage-maker. He has been troubled with a strictured condition of the urethra, the result of gonorrhea, for several years. The obstruction to the flow of urine has been gradually growing greater until now he suffers from retention and frequently from incontinence. He has at the meatus an elastic stricture No. 10 F., and a rough washboard-like stricture of caliber No. 8 F. from the penoscrotal junction forward a distance of two inches.

On January 1, 1892, I cut the first and dilated the second to No. 32 F. with Holt's Divulsor, after the method recommended by Henry Morris. Hemorrhage not severe. A catheter was not tied in the bladder, for the reason that, as I have found quite frequently to be the case, though the steel sound will pass readily, the urethra contracts upon a soft catheter of many sizes less, even under deepest chloroform anesthesia.

On January 15th the attendant complained to me that the stricture had so far closed that only a No. 15 F. flexible bougie could be introduced, and that each time an instrument is passed the patient has an attack of urethral fever.

On January 17th, under cocain, I operated upon him by my electrolyzers, both on the floor and roof of the urethra. Time of operation, one and a half minutes. Following this there was some bleeding from the granulation tissue on the surface of the stricture, and much of this tissue came away on the instrument. He had no fever following the operation, and the urethra remains at this date, April 18th, open to a No. 28 steel sound. He can retain his urine for five hours, but sometimes dribbles a little when he is fatigued.

CASE NO. VIII.—February 17, 1892, C. B., fifty-nine years old, painter. He has had gonorrhea twice, the last time in 1883. He has been operated upon by internal urethrotomy in 1879, and again in

1883; results not good. General health impaired by his disease. Urinates from ten to fifteen times every twenty-four hours. There is a stricture No. 17 F. one and a half inches from the meatus, fibrous and inelastic. From the anterior surface of this stricture to the penoscrotal junction the floor of the urethra feels as the olivary stricture searcher passes over it, like the surface of a washboard. In the bulb is another obstruction through which a No. 9 F. flexible bougie can be passed, but no filiform inserted. The face of this stricture is warty. There is an old narrow passage between the urethra and rectum which is readily entered.

February 20th the meatus was cut and the anterior stricture severed with an Otis urethrotome, and an effort made to electrolyze the perineal one without a guide, but the attempt was not successful. After this operation there was great swelling and much pain.

On March 14th, without an anesthetic, I succeeded in passing a filiform carried on an 8 F. silver-tunneled catheter into the bladder; the catheter was carried forward releasing the filiform and then withdrawn, the electrolyzer was threaded, and the stricture passed in one and a half minutes. There was no flow of blood, but the irrigating fluid used to wash the bladder was a little stained. A No. 22 soft rubber catheter was tied in the bladder for twenty-four hours. No fever and no pain followed the operation.

April 15th a No. 28 F. sound could be easily passed through the stricture, but the urethra posterior to it had become during the long period of its obstruction so much dilated that each time he urinates a considerable quantity remains in this pouch, and unless pressed out by the fingers causes dribbling for a long time afterward.

CASE No. IX.—A. W., cook, forty years old; had gonorrhea nine years ago, and has been troubled with symptoms of stricture for more than eight years. Urinary frequency great, eleven to twelve times during the day, and three or four times at night. Stricture at the meatus No. 8 F. Circular stricture of the pendulous portion of the urethra one and a half inches from the meatus, two inches long, No. 18 F. Stricture in the perineal urethra resilient and irritable, one inch long, No. 13 F.

On March 13th cut the meatus to 32 and the circular stricture to 34. Attempted electrolysis of the deep urethra, but the battery was out of order and I did not succeed.

March 7th, electrolysis of the deep stricture. Operation completed in three-fourths of a minute. The circular stricture showing a decided tendency to recontract in spite of the introduction of

sounds, was also electrolyzed on both the floor and roof of the urethra.

March 27th the two anterior strictures had so far recontracted that only a No. 12 F. flexible bougie could be introduced through them. It was almost impossible for the patient to urinate so I performed an extreme meatotomy and an external urethrotomy severing the circular stricture upon the floor of the urethra for a length of two inches. The circumference of the urethra was involved, and the surface of the mucous membrane over the whole extent of the strictured tissue was covered with warty vegetations. These I removed with scissors and curette, passed a No. 27 soft rubber catheter to the bladder, and sewed the superficial structures together over it. The posterior stricture, which had been electrolyzed, was found open, apparently smooth, and required no interference. The wound healed perfectly in five days, and the individual now takes a No. 25 F. sound from the meatus to bladder easily and urinates with comfort.

CASE NO. X.—December 9, 1896, R. H. J., farmer, forty-four years old, English. He had gonorrhea many years ago, from which there resulted stricture. Four years ago, under the influence of cold, in Montana, he had retention for a day or two. About two and a half years ago he had a similar attack while working in the coal mines of Indiana. He was injured at that time by a dirty catheter unskilfully used. About eighteen months ago on a ranche in Idaho he had a similar attack. He was cut for stricture by internal urethrotomy in Chicago last July. Stricture not passable to any instrument without an anesthetic. He has had incontinence continuously for a week, but every fifteen minutes, after great straining, passes a little urine. So great was the effort necessary for this that his face became perfectly livid, the veins standing out on the skin like cords, the eyeballs being bloodshot from the capillaries ruptured by the strain. The stricture occupies all of the urethra from the penoscrotal angle to the prostate, and there is a false passage in its floor.

December 19th, under chloroform, managed to pass a filiform through the face of the stricture into the bladder with a No. 8 tunneled silver catheter. The Fort electrolyzer was threaded upon the filiform. The operation of electrolysis lasted nearly an hour. After it was finished a No. 21 steel sound was passed to the bladder, then a catheter passed, and the bladder freely irrigated. Since the operation he always passes a free stream of urine and is very happy, but the urethra is so dense, and the face of the stricture so covered with

vegetations, that I believe sooner or later, an external urethrotomy will have to be performed upon this man. He, however, is quite well satisfied with the result of the electrolysis.

I commend this report to you, gentlemen, for your thoughtful consideration. Whatever theoretical objections may be urged against the method, I have shown that it has in selected cases a definite value. I do not think that it is either advisable or available as a general method of treatment in all urethral strictures. No treatment ever effects the entire removal of a dense fibrous infrapubic stricture, but this does as much as can be done, and with the minimum of danger. The cases reported were selected purposely from a rich clinical material for the trial of this method. They do not comprise all of those operated upon by electrolysis, but only those presenting difficult or interesting features.

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TREATMENT OF STRICTURE OF THE URETHRA BY ELECTROLYSIS.

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THE treatment of stricture of the male urethra by electricity has of late received a good deal of attention. It has been discussed in medical societies, and a number of papers have appeared in the medical journals of this and foreign countries.

The first practical experiments in this line, from which definite results were claimed, come from France, by Mallez and Tripier.

It was then taken up by Althaus of Germany, who reported a number of successful cases.

In this country it was first extolled by Newman of New York, Frank of Pittsburg, Pa., Prince of Jacksonville, Ill., and Butler of Buffalo, N. Y.

In April, 1889, Dr. J. A. Fort of Paris read a paper on "Linear Electrolysis of Stricture," before a meeting of the Academy of Medicine, Paris.

The methods in vogue at the present time are the ones proposed by Newman and Fort.

They differ in method of technic, yet the results obtained are the same.

In Newman's method the stricture is treated by electrolysis, using a series of electrodes of varying sizes.

These electrodes consist of four separate sets:

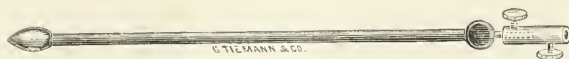
1. The egg-shaped electrodes consisting of Numbers 11, 14, 17, 18, 20, 21, 23, 25, and 28 of the French scale.

FIG. 2.



2. The acorn set, which consists of Numbers 15, 17, 20, 22, 25, and 27 French. These are straight, and are intended for use in the first six inches of the urethra.

FIG. 3.



3. The tunneled electrode consists of Numbers 9, 11, 14, 17, 20, and 21 French, and are employed in a tight and tortuous stricture over a filiform guide.

FIG. 4.



4. The combined electrode and catheter consists of Numbers 9, 11, 14, 17, and 20 French. These instruments are for very tight strictures, complicated with retention of urine. It can also be utilized in washing out the bladder.

FIG. 5.



These instruments, as invented by Dr. Newman, have been extensively used in this country and abroad, and have found favor among a number of surgeons, while other surgeons have decried their use on account of the liability of producing cauterization of the healthy urethra about the strictured part. This in my opinion need not be a drawback if the instruments be used with care, and the milliamperage be not too high.

It has been advised in using these electrodes, that those with short curve are to be preferred. This in my opinion is a mistake, the electrode with a long curve has given me the best satisfaction. By the long curve I mean that it should be from two to three degrees larger than the Thompson curve. This curve can be made to conform with the individual urethra, by placing the electrode in hot water and bending it to the proper degree.

In using the instruments devised by Dr. Newman it is advisable to select an electrode that is from one to three sizes larger than the stricture. No force should be used, the electrode should be held gently against the obstruction, the electrode will take care of itself, doing the work by the electrolytic action of the current. A séance may last from five to ten minutes, and if the electrode has not passed the stricture in that time, it is better to discontinue, as a longer application is apt to cause irritation. Sounds or other dilating instruments should not be used during the interval, which should be from one to two weeks. The electrodes should not be lubricated with substances which are non-conductors. An excellent non-irritating lubricant which can be applied to all instruments which are to be used in the urethra is as follows:

| | | |
|---|--|--------|
| R | White Castile soap, powdered | ℥ i |
| | Distilled water | ℥ iii |
| | Mucilage of Chondrus Crespus | ℥ iii |
| | Formalin (40 per cent.) | Mx |
| | Thymol | grs. v |
| | Ol. thyme | Mv |
| | Alcohol | Mxv |

This is dispensed in two-ounce collapsable tubes, and sterilized and is prepared by Fraser & Co. of New York.

Dr. Fort's electrode is constructed on a different plan from that of Dr. Newman's. It has the curve somewhat larger than that of the Thompson curve. The tip is the size of an 8 French. One-quarter of an inch from the distal end, on the concave surface, there protrudes a wedge-shaped piece of platinum. The electrode at this point corresponds to the size of 26 French. It is tunneled for a filiform guide. The conducting wire is insulated with vulcanite.

In using the Fort instrument, the technic is somewhat different from that described in Newman's instruments.

The electrode is passed down on to the stricture, the current is turned on, from five to ten milliamperes being used. The time consumed for the electrode to pass through the stricture is from thirty seconds to one minute. As soon as the electrode is through the

stricture the current is turned off, and the instrument removed. The dilatation is performed by passing Numbers 22, 23, and 24 French sounds. The patient is told to return in a week's time, and the ureter is dilated by passing the same size sounds, or larger as the surgeon sees fit.

The absorption of the stricture by the use of Newman's electrode is accomplished without the aid of other instruments, while with Fort's electrode, linear electrolysis is performed, and the stricture cured by after-dilatation with French sounds.

The method that the writer has adopted in using electricity for

FIG. 6.



the absorption of urethral stricture is described as follows:

1. If the stricture does not need immediate attention, the patient is placed on the following:

R Salol 3 i
 Ol. gaultheriæ 5 ii

M. Sig. Twenty drops in water every three or four hours.

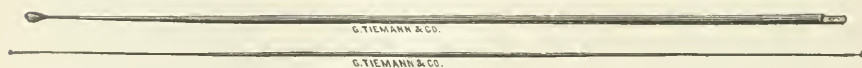
The object of this is to sterilize the urine which can be accomplished within twenty-four hours.

2. The urethra is washed out with some antiseptic solution.

3. The electrodes are made antiseptic by immersing them in a 1-500 formalin solution and then removing them to sterilized water.

4. Always make the urethral electrode the negative pole, the

FIG. 7.



positive pole can be held in the hand or placed on the thigh or abdomen of the patient.

5. Never use electricity in a urethra which is inflamed from over instrumentation.

6. The current to be used is the galvanic or continuous, and you should know accurately the number of amperes you are using. This can be accomplished by the use of the milliamperemeter. The cur-

rent should never be applied in any other way. The ordinary street-current can be used, provided it is the continuous or galvanic. All that is necessary is a rheostat, a milliamperemeter, and a volt limit selector. With the latter instrument, accidents are impossible. The number of milliamperes should never exceed ten. Less is to be desired if it will accomplish the work.

The following cases are illustrative of what electrolysis can and cannot do:

CASE I.—J. W. T. consulted me on December 15, 1896. Age thirty-five. Married. Gonorrhea ten years ago. Denies infection since. Has had trouble in voiding urine for the part year. Noticed slight discharge at times. Stream is smaller and more twisted than formerly. Sounds have been used. Washed out anterior urethra with 1-5000 hot formalin solution. Bougie à boule reveals a stricture $2\frac{1}{2}$ inches from meatus, would allow No. 18 F. to pass. Electricity applied. A No. 20 F., Newman's acorn-shaped electrode used, which passes through the stricture in two minutes. Milliampere eight. No pain or blood.

December 22, 1896, irrigated anterior urethra 1-5000 hot formalin. Electrolysis with Newman's acorn-shaped, size 25 F. Milliampères eight, for three minutes. No discomfort.

December 30, 1896, used 26 F., Newman's acorn-shaped electrode. Time, three minutes. Milliampères eight. Irrigated with 1-5000 hot formalin solution.

January 3, 1897, leaves for his home to-morrow, which is in the West. Passed a straight anterior French sound No. 26 with no difficulty.

March 5, 1897, a letter received in which it is stated that no treatment of any kind has been used since January 3, 1897. His stream of urine has not decreased in size, and has had no trouble of any description since the last treatment.

CASE II.—W. T. consulted me on January 14, 1897. Age thirty-seven, unmarried. Has had two attacks of gonorrhea. Last attack two years ago. For the past six months there has been a slight discharge, for which he has used an injection. The stream of urine has diminished in size, and is twisted at times. Washed the anterior urethra with 1-5000 formalin. Examination with a bougie à boule revealed a stricture $3\frac{1}{2}$ inches from the meatus, size 18 F. Electrolyzed with Fort's instrument. Passed through the stricture readily in one and one-half minutes. Milliampere six. Complained of no pain. No blood. Passed No. 26 sound into bladder.

January 20, 1897, irrigated with hot formalin, 1-5000. Passed 26 French into bladder. No difficulty.

January 27, 1897, irrigated with hot formalin, 1-5000. Passed 26 French into bladder. No difficulty.

Saw patient April 1, 1897. Complained of no trouble during the interval. The urethra admitted 26 French. There was not the slightest obstruction to the passage of the sounds.

CASE III.—W. T. F. consulted me on December 18, 1896. Age thirty-two. Unmarried. Three attacks of gonorrhea. Last attack one and one-half years ago. Has noticed that the stream has been growing less in size, and is twisted. This has been on the increase during the last three months. Irrigation of the anterior urethra with hot formalin, 1-5000. In passing bougie à boule discovered a stricture four inches from meatus. Would only admit a 14 F. Electrolyzed with Fort's instrument. Passed through the stricture in one minute, eight milliamperes being used. No pain. A few drops of blood. Irrigated with 1-5000 hot formalin. Passed 26 French into bladder.

December 24, 1896. Irrigated with hot formalin, 1-5000. Passed 26 F. into bladder. No difficulty.

January 4, 1897. Voids urine in a good-sized stream. No twist. No discharge. Irrigated anterior urethra with hot formalin solution, 1-5000. Passed 26 F. into bladder with no difficulty.

February 4, 1897, irrigated urethra with hot formalin, 1-5000. Urethra admits readily 26 F. without the slightest difficulty, and no obstruction discovered. Complained of no difficulty. Stream of urine is voided without a twist, and is of good size.

March 5, 1897, irrigated urethra with hot formalin solution, 1-5000. Passed without difficulty a 26 French.

CASE IV.—T. A. K. consulted me on December 10, 1896. Age thirty-four. Unmarried. One attack of gonorrhea eighteen months ago. The stream of urine has been growing less in size and considerably twisted. There has been a slight discharge during the past three months. Examination with bougie à boule describes a stricture three inches from the meatus, size 14 F. Irrigated with hot formalin solution, 1-5000. Attempted electrolysis with Fort's electrode, used ten milliamperes for three minutes. Result negative.

December 11, 1896, irrigated urethra with hot formalin, 1-5000. Tried electrolysis with 17 F., Newman's acorn electrode for ten minutes. Five minutes with eight milliamperes, and five minutes with ten milliamperes. Result negative. The stricture was later divided with Maisonneuve's guide and knife.

CASE V.—W. T. W., age forty. Married. Stricture for two years. Has been treated by sounds, but not systematically. Bougie à boule reveals a stricture four inches from the meatus. Size 16 F. Attempted electrolysis by both Newman's and Fort's electrode. Result negative. In fact the electrodes had no effect at all on the stricture mass. Relieved by internal urethrotomy.

CASE VI.—W. J. S., age forty-two. Married. Stricture in the posterior urethra. Electrolysis by the use of Newman's and Fort's electrodes made not the slightest impression. Relieved by external urethrotomy.

In conclusion, from the experience that the writer has had in treating stricture of the urethra by electrolysis, he believes that he is justified in stating that by the electrolysis, properly applied, soft strictures wherever situated, can be safely and surely treated by this method, conjoined by dilatation to a moderate degree. When the patient is to pass from your care instruct him in the use of the sound, which he is requested to pass at least once a month for the first two or three months, and then at longer intervals. If at any time he experiences any difficulty in passing the sound, to seek the advice of a physician at once. The sound to be not larger than a 26 F. By this form of treatment anesthetics are not required. There is no pain to speak of. As a rule, there is no hemorrhage; there may be a few drops of blood, but nothing like that which follows division of a stricture by the knife. The object of electrolysis is to absorb the stricture, not to destroy it by cauterizations, for if the latter be done you have a worse state of affairs than before the electricity was applied. In after-dilatation, do not try to find out how large a sound you can pass. No. 26 F., in the writer's opinion, is large enough. Over-dilatation and frequent instrumentation have ruined as many urethras as has gonorrhea.

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A CASE ILLUSTRATING INDIVIDUAL RESISTANCE IN ELECTROLYTIC WORK.

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FURTHER than a mention of variability in patients during electrolytic work, as regards susceptibility to the current, there is little to be found in the books regarding resistance to the current. The following case seems to demonstrate that some persons have a greater tissue-resistance to, or are capable of becoming "charged" with, electricity. We hear of "electric" people, many of them frauds, and we know that some animals are more susceptible to a current than human beings. It is reasonable to suppose that people may vary in this respect just as they are known to vary in so many other particulars.

The case in point is, briefly, as follows: In November, 1895, I removed 745 hairs from a young lady's face, with no milliamperemeter in the circuit, using the current from seven cells of the "Law" type—not recently renewed. The work was done in seven days. There was no suspicion that the current obtained was not sufficient.

In May, 1896, she returned with the statement that most of the hairs had regrown, though she did not remember to allow for a number of cut stubs which I did not treat. Until my experience with the second operation, I simply believed that the short time allowed for the first had caused the too hasty removal of the hairs, and thus insufficient destruction of their papillæ. I am now inclined to think that there was then present this unusual resistance, which gave me so much trouble in the last treatment. Unfortunately, I had been doing the work for several years "by the books"—by cells, instead of with the milliamperemeter, to measure the current.

The first séance, in the second series of operations, was about one and three-quarters of an hour. Seventy hairs were removed, with the greatest care. The meter showed an average current of one-half milliampere. The number of cells was increased the next day, the meter then showing an actual current of three-quarters milliampere, but it soon ran down to one-quarter. Both the "Law" and the Kidder batteries were then thoroughly gone over and every discoverable defect remedied. I formed a series of seven "Law" and ten Kidder cells. Then I inserted the terminals of the poles in

a piece of lean, raw beef, with about six inches between them. With the meter in the circuit, I let the current act for one hour. There was no variation in, nor decline of, the current. I obtained the same result with the poles in a cup of water. This relieved the batteries of responsibility for primary insufficiency, or early exhaustion. Either set of cells alone showed no deficiency.

At the beginning of the treatment next day I had a current register of two milliamperes, and removed twenty-five hairs with comparative ease, but this—originally too strong—current, which had been gradually falling, then rapidly went down to 0, showing that the site of operation was getting no current. At the succeeding operations, the current-register with the first hair was one and a half to one and a quarter milliamperes, but it steadily fell to 0 by the time the third hair was reached.

Then the sponge-electrode was grasped in my hand and the needle applied—at the negative pole—to my tongue. There was no absence of current nor failure of the meter to register. This was further tested in the destruction of a small wart on my right hand, the current passing through the tissues intervening between the two hands.

Upon the theory that the patient became surcharged in the area traversed by the current from the hand to the face, I tried a change of hands as soon as the meter-needle began to go back to nothing—about the third hair. I would then get the full current desired, for about two hairs, and the rest of the treatment was given by this method of frequently changing hands. When the register was 0 there were neither subjective nor objective symptoms in the follicle.

There is but one weak point in the chain of evidence, and that is the fact that one day the patient showed an abnormal susceptibility to the current, as demonstrated by the meter and her sensations. I can account for this in no way save on the theory of greater contact having been obtained through a bleb formed on the palm by an exposure of a portion of the metal of the positive pole, which was not discovered, and consequently not rectified, until this accident occurred. Another day a current of three-quarters milliampere, obtained by frequent change of hands, produced faintness and weakness, after a necessarily long séance of two and a half hours, though only fifty hairs were removed.

Having eliminated every possible element of resistance, short-circuiting, or deviation of the current, it seems to me that this is one individual in whom there existed a certain tissue-resistance, or power of accumulation of electricity in the parts through which the

current passed. Naturally other cases should be collected to sustain the views advanced, but one case logically proven should be of sufficient value for publication, if only for the purpose of further developing our knowledge and experience in electrolytic work.

This case also demonstrates the necessity of the use of a galvanometer, in preference to the *number of cells*, as a guide. The subjective and objective symptoms are too uncertain. The meter is tolerably certain. It is possible to *think* you are doing the work when you are *not*.

Since the above was written I have had opportunity of proving the different resistance of different individuals who were treated during the same hour.

A young lady was given the current from hand to hand, for the destruction of a wart. The meter registered one-half milliamperere. Immediately afterwards I used the same current from hand to hand on a young man, for the destruction of a small wart. The meter showed a net current of one milliamperere. The wart on the lady's hand was the larger, but was treated deeply. If the thickness of the epidermis afforded an explanation of resistance so various we would have expected that the man would have got the least current. But the fact was the reverse of what we should expect.

The lady was a stenographer, her occupation certainly not tending more to produce a thickening of the palmar epidermis—upon which the positive pole rested—than that of a medical student, whose palms were at least subjected to as much friction. I could see no abnormal thickening, or thinning, of epidermis in either case.

I submitted the report of the first-mentioned case to a prominent dermatologist, who has done much electrolytic work, and his reply was, in spite of my proof to the contrary, that the trouble must be in my battery, or its connections. A physician, to whom the matter was submitted by a battery manufactory, made a similar reply.

I am convinced that there was some—to me at least—mysterious resistance in the first case and a positive difference in the two last.

Milliamperemeters are considered unreliable by many, but even if they are, the feelings of the patient, the visible effect of the current, and the result of its use are no better guide.

Another curious feature of the first case is the scarring with which I was afterward charged. When the meter failed to register, the patient felt no current, there was no frothing around the needle, no electrolytic action. Yet the long continuation of a vari-

able current—in the effort to finish the work—seems to have been productive of the scarring complained of.

No man has yet mastered the entire mysteries of electricity, and I do not claim to have mastered the little galvanic current represented in milliamperes. It is at least an excuse for bringing forward peculiar cases, that we may learn much from the preservation and record of each variation from the supposed-to-be-usual.

I hope, if I am in error in my conclusions, that some one will be so good as to present logical evidence of that error, and not fall back on an impossible explanation, in the light of my proofs.

NOTE:—Since writing the above paper I have had a further mystifying experience with a new outfit. It was the case of a lady of twenty-five. I removed nearly 500 hairs from the face—with the positive sponge electrode in the patient's left hand—and there seemed to be no trouble. Then, with the electrode in the same hand, I did two day's work on the chest. On the third day, and for over a week of daily operation following, the electrode in the left hand gave from 0 to only one-fourth as much current (as shown by the meter) as it afforded when held in the right hand, and this without regard to which side of the body was receiving electrolytic treatment. A gold ring on the left hand had no influence, off or on, and the patient was right-handed, and the epidermis of the left showed no difference from that of the right. I had to abandon the use of the left hand as a contact area for the positive electrode.

311 and 312 Fitten Building.

Correspondence.

A NEW HUMAN PARASITE OF THE SARCOPTIC TRIBE.

EDITORS JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES:

In April last year a peculiar chronic disease in an aged person came to my notice through a friend, Dr. Wm. Fleming of Georgetown, Texas, who was attending the case. Concerning the symptomatology, Dr. Fleming kindly favored me with the following data: "About eight months ago my patient became afflicted with the disease and has been a great sufferer ever since. The disease appears with small papules here and there, from a pale to a fiery red, and at times under treatment will seem apparently well, but on application of ointments or lotions reappear in greater or less number and larger or smaller lesions. The disease is not attended with itching, but when very red has a slight burning sensation. The animaculæ, it seems, on maturing, emerge from the skin, and in some places

seem to discharge germs covering a space more or less dense from a half to two inches in diameter. The various remedies I have used have caused many of all sizes to come to the surface, some bore under the skin again, and although I have picked off thousands, I have never seen one move. One of the great annoyances to the patient is their crawling on the skin. Their bite is much like that of a flea or a chinch, and often so rapidly is it done that the mite will bore in before you can pick it off with the point of a knife. The bites and pimples never suppurate nor exude serum.

"I have given six months of study and investigation to the disease and have found nothing in our medical literature which at all resembles it. I have carefully watched him, so that he could not deceive me nor anyone else. Besides, he is too anxious to get well for a malingerer."

The doctor and also his patient have forwarded samples of the material gathered from the sick man's body for me to examine microscopically. After proper mounting (in glycerin and dilute acetic acid; also, in Canada balsam) the main ingredients seemed to be inorganic and of a calcareous nature (giving off carbonic acid on applying acetic or nitric acid) and a major part showed remnants of cuticular tissue and detritus, a number of oval bodies, which, on pressure under the coverglass, produced a crackling noise. In a number of these slides I noticed several peculiar microscopic mites, and in a few instances larvæ and casts of these parasites. Being somewhat suspicious, I again addressed a letter to Dr. Fleming, and received the following answer:

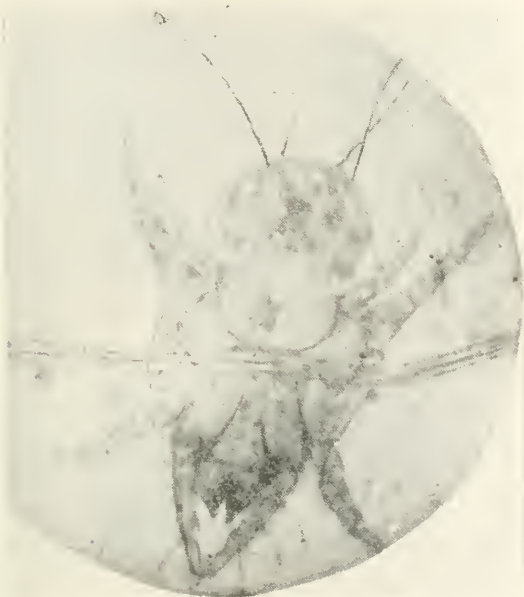
"I assure you that every particle of the samples I sent you came from his body. He never has taken a sand bath; he always washes himself in hot water, as it seems to give him more relief. I have watched him closely for six months and have tried every known remedy without success. The particles of sand-like material or shells, or whatever it is, all come from him, and are not put on him by washing or any application. When I use vinegar on him there will come out on his body more sand or shells, and in the morning his body contains more than in the daytime, keeping him awake through the night. I have scraped regular barnacles formed by the insects at night from between his toes and creases of the arms and elbows," etc.

After these statements I gave the matter closer attention, especially regarding the parasites found, as, from first appearance it appeared to me that the mite was not a species of the common acari, found occasionally in decaying material or detritus, or in fruit, vegetables, cheese, flour, etc., but that it was a true sarcoptes—not, however, the common itch parasite of man. In this opinion I was sustained by Dr. A. E. Boecking, an expert on parasitic mites, and also by Professor Allen J. Smith, Pathologist of the Galveston University. Both of these gentlemen had taken a great interest in this seemingly trivial matter, which, of course, could only be settled by a close microscopic examination and comparison with other similar mites. Having secured one especially fine specimen among the cu-

ticular scrapings, I mounted it separately from the other remnants and forwarded it to Professor Virchow, after having it investigated by our Smithsonian experts, etc., but never received a reply from Berlin (perhaps it had not reached its destination).

This mite is of the size of the common itch-mite, hardly visible to the naked eye, of yellowish-brown color, supplied with

FIG. 8.



eight legs, five jointed, and the pedal extremities are supplied with a sucking disk—characteristic of the sarcoptes or itch-parasites.

FIG. 9.



Larva of Sarcoptic Mite. Photomicrograph by Author.

The eight legs are decidedly thoracic, not marginal, and the specimen preserved was a *male* one—the sex found being considered by

experts as of very rare occurrence. In comparing this mite with the common cheese-mites and fruit acari, our mite shows the legs, jaws, abdomen and bristles more fully developed, the latter closer to the base of the abdomen, larger, and thicker.

As seen on the photo-reproductions, I succeeded in making several microphotos of the parasite in different stadia, and also of the larva. The latter is six-legged; the body and legs were semitransparent and dotted throughout. I have not encountered any such larva in microscopic mites before. The Smithsonian experts also declared it to be the larva of the parasite under question.

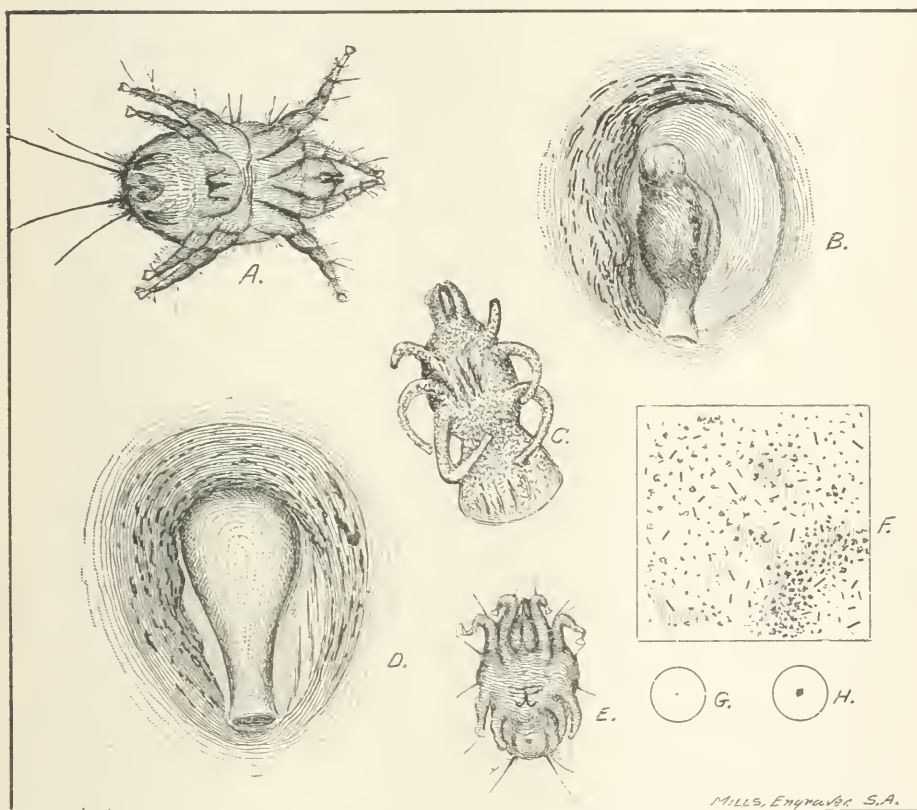
Professor Allen Smith, in October, 1896, had given me a very interesting report on sarcoptic mites in general, and of our acarus in particular, and I only include here the following points: "I have been looking up all the data I can get hold of in my endeavor to identify the dermal parasite. There seems to me to be no doubt of the parasite being an acarus. The mode of articulation of its legs, the fact of its having five divisions to each limb, its cheliform or pincers-like jaws in my mind place it surely among the sarcoptides. (Here follows an exhaustive explanation of the five tribes of the sarcoptes family, having used as guide, *Méguin*: "*Les Parasites articules*." The five tribes are: *Sarcoptes detricoles*, *S. plumicoles*, *S. cysticoles*, *S. glyci-coles*, and *S. sporæ*. . . . The specimen in hand cannot belong to the first tribe. It differs in being provided with a somewhat rugous integument, in having unequal limbs, and, I believe, dissimilar in having a distinct cleft in the abdominal extremity. It is not to be mixed up with the bird-infesting sarcoptes (*S. plumicoles*)—the latter has all its legs well developed, and never even tending to be abortive (as in the last pair of R.'s parasite) and never produce painful or itching sensations (by some poison in its bite). . . . I would place R.'s parasite, from its shape, its somewhat striated coat, its undeveloped hind pair of legs, and its power to produce itching, among the true itch-sarcoptides. . . . I believe the R. parasite to correspond with the genus of *chorioptes*. As to species, I am still uncertain, but believe it to be *C. ccaudatus*. . . . I see no hairs on the third pair of legs (they are present on this parasite, but were unclear or not visible on the microphoto. R. M.) and only two clearly on the abdominal border. I cannot make out the dorsal plate, etc., since the photograph from which I must take my points only gives the ventral surface. . . . Aside from these, the description suits well, and if these differences are real I believe that at least the genus is correctly fixed, and the species perhaps a new one."

Dr. Boecking called to my attention that, if the above diagnosis of the parasite be applied to a *mature* specimen, it seems, indeed, to point to a cheiroptes, were it not for the fact stated in regard to the position of the extremities, which are *thoracic* in our mite, and not marginal.

I have compared our parasite with a number of mites of old fruit and cheese, and it differs in being a smaller and "bolder" appearing acarus, and the endpads of the legs, on high-power exami-

nation, showing a stirrup-shaped *discus* or *sucking-cup*. This distinguishes the sarcoptes genus from similar acari. In microphotography, of course, only such objects and outlines can be copied as come under sharp focus of the lenses of the microscope, especially in making a microphotocopy of such a minute object as our mite under a very high magnifying power. For this reason the outlines

FIG. 10.



- A. The parasitic mite; legs fully stretched out. (x: ab. 400.)
 (The position of the hair or bristles on hind body and the legs is correctly copied, but the fine short hair along the feet and body are superfluous—else the engraving is a true and fine copy of the original microphoto.)
 B. Globular cystic body with remnant of larva cast in the interior cystic inclosure. (x: ab. 200.)
 C. Larva of the same acarus. (x: ab. 500.)
 D. Oval or pear-shaped cystic body with funnel-shaped outlet. (x: ab. 200.)
 E. The parasite with feet contracted. (x: ab. 300.)
 F. General appearance of the raw material sent for examination.
 G. Dot in center of ring showing the normal size of the parasite.
 H. Largest size of the globular, dark-brown opaque bodies.

MILLS, Engraver, S.A.

of the terminal parts (sucking-cup) of the legs are not so sharply outlined as the rest of the parasite's body.

This case of parasitic disease seems to be unique in many particulars regarding etiology and symptomatology. With the exception that it was noticed over nearly the entire body, the symptoms, as stated by Dr. Fleming, would distantly tally with those of the *common itch sarcoptes* of man; but, as noticed, had patient the usual itch plague, there certainly would have been found remnants of the itch-parasite and its larva, ova, etc.; and then, the itch disease is easily amenable to rigid antiparasitic treatment. The specimens or remnants from scraping of the skin sent to me were, of course, in a dried-up state; they formed a yellowish-brown, granular powder, showing, on examination, numbers of cuticular and more deeply-seated remnants, capilli (sparingly), calcareous remnants, some granular (apparently hemorrhagic) detritus, shed skins of microscopic mites, and the parasites, either entire, but contracted, or in remnants (partly incrustated, it seemed). The latter were *dead acarine*, and the one specimen, now under question and illustrated, had its legs contracted when first found, but, under coverglass pressure, the legs were gradually spread out.

In conclusion, I beg to call attention to the fact that an article on this subject has been published some time before, but the same was full of typographical errors and the photo-illustrations of the parasite were not as good as desired. It is for these reasons that the matter is hereby again brought before the profession. I may also state that I had sent the article (in pamphlet form) to a large number of experts and medical institutions here and in Europe, and received from none any data concerning a similar parasite. The authorities of the Zoological Institute of Genoa, Italy, have sent me, in return, some literature on microscopic mites, with illustrations, but no such mite is mentioned. Whether, in our case, the parasites had been implanted accidentally on the patient from some animal infested with a sarcoptic disease, or from some other unknown source, of course can only be conjectured, but the fact remains that the entire case, as above described, is unique, and the parasites found are some *uncatalogued sarcoptes species*—in my own humble opinion at least. The cuticular scrapings, as stated, contained a vast variety of superficial cuticular abrasions and deeper-seated products, especially of the follicular system of the derma, and among these were remnants of the parasites, some seemingly incrustated and surrounded by a calcareous encasing.

The *sarcoptes* species in different animals differ from the one under consideration in many respects, and it is for this reason, and in particular, also, as the parasites, larva, and remnants of same, etc., were found in scrapings removed from the body of *man*, that this is such an interesting study, even were there found no parasitic vestiges, and it would be interesting to hear, through this journal, of a similar case on record.

San Antonio, Texas.

RUDOLPH MENDER, M.D.

SEBORRHEITES.

PARIS, June 19, 1897.

TO THE ACTING EDITOR:

Dear Sir: I have just read in the June number of your journal an analysis of one of my clinical lectures on the seborrheic eczematata which I had proposed to call seborrheites, in order to distinguish them definitely from true eczemas. Not without some reason your collaborator declares that this new word is, "etymologically, an indefensible abomination." I am accustomed to accept every criticism which is made on my work, even when it is formulated in rather a severe fashion—provided that it is well grounded.

I must, therefore, thank you for the criticism which has been made, and which I was brought some time since to regard as just. For that reason, and others beside, I currently employ in my lectures the term *seborrheide* in place of *seborrheitis*. I do not pretend that the new word is good—far from it—but it is not open to the same objections as the other I proposed, and I avail myself of it while waiting for a better to be furnished me.

I shall be obliged if you will insert this letter in your journal, as it comes from one of your earliest collaborators.

With kindest regards,

L. BROcq.

[It seems unlikely the new term will find any readier acceptance than the first. *Idc* is a termination used to indicate, by common consent, a granulomatous process, as in syphilide, tuberculide, lepride. The characters, clinical and microscopical, connoted by this termination, are, in the light of present knowledge, not those of seborrheic dermatitis.—ED.]

Society Transactions.

THE NEW YORK DERMATOLOGICAL SOCIETY.

TWO HUNDRED AND SIXTIETH REGULAR MEETING, HELD ON
TUESDAY EVENING, MARCH 23, 1897.

DR. J. A. FORDYCE, *President, in the Chair.*

A Case of Nævus Unius Lateris.—Presented by DR. P. A. MORROW.

The patient was a young married woman, with a peculiar, streaked eruption on the left side of the back and neck, down between the shoulders and with striated papillary lesions extending down the back. The distribution was unilateral. It had existed for seven years. It bore a strong resemblance to lichenoid eczema and was probably neurotic in origin.

DR. E. B. BRONSON regarded the lesions as neuropathic in character, similar to those met with in ichthyosis hystrix.

DR. C. W. ALLEN said that to him the case looked like one of lichen planus.

DR. GEORGE T. JACKSON said the lesions were evidently of neurotic origin.

DR. S. SHERWELL said that Dr. Morrow's patient had been under his care for a time about six months ago. When he first saw it he regarded it as a form of unilateral *nævus*. Afterwards he changed his diagnosis to neurotic eczema, which he still regarded as the correct one. From the appearance of the lesions at the present time, they had evidently remained stationary, both as regards size and location. The superficial elements only were affected by treatment, which was of the same character as that now used by Dr. Morrow.

DR. G. T. ELLIOT said the case had impressed him as being one of *nævus unius lateris*. Its character, he thought, would have been more apparant if no treatment had been undertaken, as its warty and keratotic elements had been removed by the salicylic acid plaster. He had observed cases somewhat similar which he had looked upon as being forms of lichen planus or of neurotic eczema, but they were always bilateral in character. In Dr. Morrow's case he saw nothing that resembled eczema; there had never been any weeping nor itching; and it was merely a warty condition with a certain amount of exfoliation of the epidermis. He thought it could be properly considered a *nævus*, on account of the linear distribution on the back.

DR. ELLIOT referred to a case of *nævus unius lateris* coming under his observation where the lesion extended from the middle of the the nose upwards to the forehead, and directly in an opposite direction to the cleavage lines of the skin. Unless we enlarge the category of eczema, he did not see how this case could be included under that head. He suggested that a microscopical examination of the lesion be made. In one case of supposed *nævus unius lateris* he had found that the lesion consisted of an adenocystoma of the sweat-glands.

A Case of Alopecia Areata.—Presented by DR. C. W. ALLEN.

The patient was a young man who had been presented to the Society on a number of previous occasions for a variety of skin lesions. At one time he had an *acne varioloformis*, of which he still showed the typical scars on the face. At the present time he has a patch of alopecia areata on the chin which has existed for eight months. During that period, Dr. Allen said, the patient had been cured of a number of similar patches on the scalp and on various parts of the bearded face.

DR. KLOTZ said he had observed similar cases, in one instance lasting for years. Bald patches were following each other on different localities, which were not treated at all and healed spontaneously.

DR. E. L. KEYES referred to a case where several patches got well without treatment.

DR. S. LUSTGARTEN said that cases of this character are not

unusually met with. They are generally very obstinate and are apt to relapse.

DR. ALLEN, in closing the discussion said he had another patient under his care who has several patches of alopecia on the neck and chin, and that almost as rapidly as one patch becomes covered with hair another develops.

A Case for Diagnosis.—Presented by DR. SHERWELL. Eruption of years, standing; papular, hemorrhagic, chiefly manifested in limbs, more particularly lower limbs.

The patient is a man fifty-three years old; married; a native of Ireland. About three years ago he had an attack of inflammatory rheumatism which lasted thirteen weeks. Just previous to that attack he had an eruption similar in character to the present one. About a year ago the present punctate eruption appeared, first on the extensor surfaces of the lower limbs, and later, to a lesser degree, on the elbows. This eruption has persisted ever since. There are no subjective symptoms, excepting slight pain in one foot. The urine is normal. Dr. Sherwell said he was inclined to think that the case was one of peliosis rheumatica, though not typical.

DR. JAMES C. JOHNSTON said that from the remains of lesions on the forehead and back of neck, which were removed from the blood stasis apparent in the lower extremity, he was inclined to regard the case as a dysidrosis. The lesions on the extremities and on the lower part of the body were of the same character, with the addition of an extravasation of blood.

DR. LUSTGARTEN said he was not much inclined to regard the eruption as a dysidrosis. He would rather classify it as one of the forms of lymphangioma. It seemed that the hemorrhagic element was not an essential one, as it did not exist in connection with the lesions on the face and upper part of the body.

DR. SHERWELL, in closing the discussion, said he hazarded the diagnosis of peliosis rheumatica because a similar eruption had preceded the man's previous attack of rheumatism. Dr. Lustgarten referred to the absence of hemorrhagic spots on the face. Dr. Sherwell said they very seldom do appear there in purpura of any kind. While he did not wish to insist on his diagnosis of peliosis rheumatica, there was evidently an extravasation of blood into the skin, which was probably due to rheumatism or some other dyscrasic element, the solidity and persistence of the papular element was the one thing that was interesting and peculiar in the case.

A Case for Diagnosis.—Presented by DR. ELLIOT.

This was the same patient who had been presented by Dr. Elliot at the two previous meetings of the Society. The patient was a man with an eruption covering the face and body; it first made its appearance in July, 1896, beginning on the forehead and gradually progressing downward over the body. The lesions originate in a peculiar manner: there is first a feeling of papulation deep down in the cutis; this becomes more prominent and redness makes its appearance. The lesions then remain unchanged for a

long time. On the face a number of small superficial papules developed, which, when they disappeared, left a brown atrophic spot behind.

Dr. Elliot said that when he first saw the patient he regarded the case as one of syphilis. For three weeks the man received one-eighteenth of a grain of bichlorid of mercury, three times daily. He was then given twenty-two inunctions of ordinary blue ointment, of one dram each, when he became salivated. Since the last meeting he had received twenty-eight additional inunctions of the same character. In spite of this vigorous specific treatment, the eruption was more prominent than ever before; it had steadily progressed, new lesions having made their appearance on the arms, back, and legs. A few of the lesions on the face had run their course, having undergone involution and left brownish cicatrices behind.

Dr. Elliot said he was now positive that the case was *not* one of syphilis and he again presented it for diagnosis.

DRS. KLOTZ, MORROW, AND KEYES said they did not regard the case as one of syphilis. Dr. Taylor said he did not care to venture an opinion again until he had had an opportunity to see the eruption by daylight. Dr. Fordyce said he did not consider the case one of syphilis. He thought the lesions began deep down in the cutis, possibly about the sweat-glands.

DR. ELLIOT, in closing the discussion, said that when we take into consideration the evolution of the lesions from the beginning, he was inclined to agree with Dr. Fordyce that the eruption was a sweat-gland disease, and could be placed in that group of cases which includes acnitis, folliculitis and universal acne varioloformis.

A Case of Pityriasis Involving Patches of Alopecia Areata.
Presented by Dr. Fox.

The patient was a young man, with several patches of alopecia areata on the scalp. These patches were covered with a new growth of perfectly white hair. The man also had a scaly eruption on the scalp and neck involving the bald patches, which the speaker regarded as a pityriasis capitis, or seborrheal eczema. Over the sternum, as well as about the umbilicus and on the thighs, there was also an eruption similar in character to that on the scalp. The latter would probably be termed by many an eczema marginatum. The eruption had made its appearance about eight months ago.

DR. MORROW regarded the case as one of seborrheal eczema. He did not think the alopecia was of syphilitic origin, but regarded it as an example of alopecia areata. It is not uncommon to see a scaly condition of the scalp when the bald spots begin to be recovered with hairs, and it is a very common occurrence to see the hairs come in white. None of the spots were perfectly bald, all having some vestige of hair.

DR. BRONSON said that while the case was no doubt one of seborrheal eczema, it did not impress him as being one of alopecia areata. The scalp was not completely denuded, nor were the bald patches as sharply circumscribed as is usually the case in alopecia

areata. The moth-eaten appearance of the patches resembled the condition met with in syphilis.

DR. LUSTGARTEN said he agreed with Dr. Bronson that the picture presented by Dr. Fox's case was not a typical one of alopecia areata. The patches were irregular in shape and not sharply outlined. Some of the lesions are rather larger than we should expect to see in a syphilitic alopecia.

DR. ELLIOT thought the case was a typical one of seborrheic eczema. He did not regard the case as one of alopecia areata, but rather as an unusual case of alopecia due to the seborrheic eczema. It frequently occurs, in bald spots due to the latter affection, that the hairs grow in white.

DR. SHERWELL expressed the opinion that the major part of the eruption was a seborrheic eczema, which on the scalp often causes a persistent loss of the hairs. He had seen cases where the bald patches were afterwards covered with hairs that came in white.

DR. ALLEN said that he had at one time presented to the Society a case of seborrheal eczema with a patch of alopecia on the back of the head which resembled alopecia areata much more closely than did the patches in this case. In his case the patch was white and smooth, and in the immediate neighborhood there were numerous lesions of seborrheal eczema as well as upon the back. He expressed the opinion that this affection may cause an alopecia very closely simulating alopecia areata.

DR. KLOTZ said the history of this case should be taken into consideration. As he understood the man stated that some of the bald patches had existed for two years and longer, while the eczematous lesions only appeared eight months ago. He could not see any reason why a seborrheic eczema should not establish itself on a region previously affected by alopecia areata.

DR. FOX, who had presented the patient, said he had no doubt that the case was one of alopecia areata. He had seen many cases of that affection where the patches are limited in size, as in this instance. The localization of the patches, their persistency, and their absence over a large portion of the scalp which is the seat of the seborrheal eczema would lead him to believe that the alopecia had nothing whatever to do with the dermatitis. The man gives no history of syphilis and he did not think the alopecia was of that origin.

With regard to dermatitis existing on various portions of this man's body, Dr. Fox said he did not think that the name eczema seborrhoicum should be applied to it. He objected to the term seborrhoicum as misleading, and he doubted if the case was one of true eczema. The eruption was as distinct from eczema as it was from psoriasis, and resembled both. The lesions in the genital region, he thought, would be regarded by many as an eczema marginatum.

DR. H. G. PIFFARD said he was in accord with the protest made by Dr. Fox against the use of the term eczema seborrhoicum. The speaker said that he was the first to show a case of that kind to the

Society, and at that time no one had suggested the idea of an eczema. That new-fangled term was later invented by Unna, who subsequently entered a strong protest against it himself by stating that it was not a disease of the sebaceous glands. Dr. Piffard said that about a week ago he saw a patient with lesions on the thighs exactly similar to those in Dr. Fox's case, which were probably due to the trichophyton, as the infection was traced to a cat. Cats are subject to trichophytina, but not to seborrheal eczema.

DR. FOX said they all knew what is meant by eczema seborrhoeicum. They knew it did not mean either an eczema or a seborrhea.

DR. ELLIOT said that seborrheic eczema was first applied to describe a catarrhal inflammation of the skin. The condition was supposed to implicate the sweat-glands, and to stimulate the excretion of fatty matter. It was, therefore, not so very wrong to call it a seborrheic dermatitis. He did not see why there should be any objection to calling such an eruption an eczema. He thought it would be difficult to give a definition of eczema which would be satisfactory to every one. The majority of men to-day regard the term eczema as merely a generic name to represent a catarrhal inflammation of the skin, and by no means a specific disease. We have names and names, and some of them, while they may not represent any certain condition, still convey a certain meaning to us.

A Case of Folliculitis Decalvans.—Presented by DR. KLOTZ.

The patient, male, 30 years of age, a native of Austria-Hungary, twelve years in the U. S. A. has for the last six years been continuously affected with a disease of the scalp; pustules and boils having almost constantly occurred there. The top of the scalp was almost devoid of hair, presenting the appearance of scar tissue, with some particularly deep cicatrices, the result of surgical interference with the abscesses. The surrounding portions of the scalp, when first seen a few weeks previously, showed numerous pustules and crusts with infiltration extending to various depths in the cutis and numerous small circumscribed bald spots and scars. Larger bald areas were nowhere visible, but in the peripheral portions there were several patches with apparently perfectly healthy skin, on which the hair is gray. The number of pustules, crusts, and infiltrated spots has steadily decreased during the last weeks under the use of a salve containing ten per cent. of sulphur and three per cent. of β naphthol.

DR. LUSTGARTEN, who had seen the case before, said he agreed in the diagnosis. Improvement had taken place after epilation and antiseptic applications, but later it relapsed.

A Case of Xanthelasma.—Presented by DR. C. W. ALLEN.

The patient was a man who had come under the speaker's observation about two weeks ago with two very pretty lesions of xanthelasma on the upper eyelids. The speaker said he operated on the lesions with his flat electrolytic needle, which he had on a former occasion exhibited to the Society, and by means of which the work could be done very rapidly, and presented the advantage of complete removal at the time of operating. The lesions had required but a single application.

DR. FOX said he had had excellent results in the treatment of these cases by means of electrolysis, but in all of them there was a well-marked tendency to relapse. He thought a relapse would occur in Dr. Allen's case.

DR. LUSTGARTEN said he considered the electrolytic treatment of xanthoma by far the best. He recently saw an elderly lady on whom he had operated for this trouble in Vienna, ten years ago, and no recurrence had taken place.

A Case for Diagnosis.—Presented by DR. C. W. ALLEN.

The patient was a woman 36 years old, who had been referred to him by Dr. O'Neil, on January 30, 1897. For nearly five years the woman had been troubled with an itching eruption upon the shoulders, arms, and hands especially, but also on other parts of the body. Since six weeks there had been a marked pigmentation of the neck, shoulders and arms, like lentigo, but some spots are quite large. The face is studded with dilated vessels, which gives to it a permanent red appearance. This has recently developed. The palms are dry and burning, and boiled sago grain papules are seen and felt projecting slightly or not at all above the surface. These look as though they contained fluid, but upon piercing or scraping them out they are found to be wholly composed of dried epithelium, and the base upon which they rest is slightly red or hyperemic in the central part. There has never been any moisture associated with any of the lesions observed, and the patient says they are always dry.

Upon the shoulders inspection may detect only the pigmented spots. Passing the hand over the surface we feel a slight roughness. Scratching or irritating produces hyperemia, without itching, and small lesions not before to be made out rise up. Upon the face there are a few mole-like lesions of firm consistence, which, the patient says, have recently developed, and upon the back and chest are about ten small angiomatic papules, which she says were never there before.

DR. ALLEN said the patient is a subject of dermatographism, a condition which he would separate from factitious urticaria. She has never had urticaria, although her sisters have. The wheals brought out give no subjective sensations.

DR. LUSTGARTEN said he thought Dr. Allen's patient presented the prominent features of xeroderma pigmentosum. The location, appearance, and irregular outlines of the eruption all pointed to that diagnosis. The warty lesions she has had, and which had been removed by Dr. Allen, are one of the essential elements of the process. The dermatographism, referred to by Dr. Allen, does not belong to xeroderma pigmentosum, and may have occurred as a complication or coincidence. The lesions on the palms also do not belong to the disease mentioned and must be considered as arsenical warts, which view is borne out by the history. The late onset of the eruption in this case does not necessarily exclude xeroderma pigmentosum. He did not think the lesions on face, neck, and arms could be ascribed to the use of arsenic.

DR. P. A. MORROW referred to a case of brownish discoloration of the skin, shown by him to the Society several years ago, due to arsenic, which corresponded very closely to the case shown by Dr. Allen, excepting in the location of the lesions.

DR. JOHNSTON, in discussing the point brought up by Dr. Lustgarten regarding the late onset of xeroderma pigmentosum in this instance (presuming that to be the correct diagnosis) said that at the last meeting of the International Congress Falçao had reported four cases of this affection, all in women, the youngest being seventy-two years of age.

DR. ELLIOT referred to a case in a man sixty years of age which had been seen by Riehl.

Measurements of Skin Lesions.—A paper presented by DR. C. W. ALLEN.

DR. FOX thought the general idea contained in Dr. Allen's paper was a good one, but he hardly regarded it as practical. Instead of establishing a new, arbitrary unit as the basis of measuring skin lesions the speaker thought it would be better to adopt the French millimeter.

DR. PIFFARD said he thought the millimeter of the metric system was certainly small enough to be taken as the unit of measurement.

DR. LUSTGARTEN said that if we adopted the millimeter as the unit of measuring skin lesions it would practically be an adoption of the metric system.

DR. ROBINSON said that while he agreed with the reader of the paper regarding the need of accuracy in measuring skin lesions, he did not think the scale suggested by Dr. Allen would simplify the matter.

DR. MORROW said he considered Dr. Allen's plan very ingenious, but entirely impractical.

DR. JACKSON said Dr. Allen's plan was ingenious, but it seemed that, after stating that the metric system of measurement was objectionable because it was not understood, the author had after all adopted it. He thought that the metric or any other recognized standard of measurement answered our purpose.

DR. ALLEN, in closing the discussion, said it was not his idea to adopt the metric system. His unit of measurement, which he called a mill, was an arbitrary unit, which, if desired, could be converted into the metric system.

Selections.

GENITO-URINARY DISEASES.

Treatment of Tubercular Cystitis. DR. BANZET (*Ann. d. Mal. d. Organes G. U.*, 1897, p. 561).

This article formulates the methods pursued by Guyon and his followers, and covers pretty thoroughly the diagnosis; topic and general treatment; surgical intervention, when best performed; the operation of choice, perineal in men, urethral in women; suprapubic in both; their advantages and disadvantages, and the indications for their performance.

Diagnosis and Prognosis.—There are two general types of the disease, one with sudden onset, accompanied by an eruption of numerous miliary tubercles, bacilli easily found; on the other hand the lesions may be few, rather slow of development, bacilli may be difficult to find or not to be found at all. These latter naturally, in the long run, give a better chance of successful treatment, though cases of the severer type may yield to treatment. Some cases have a tendency to fibrous formation, others to cheesy degeneration. This affects the prognosis. Absence of bacilli does not exclude diagnosis of tubercular cystitis. A spontaneous cystitis, with purulent urine, pain, and frequency, with absence of micro-organisms, points to a tubercular cystitis. Even when large numbers of other micro-organisms are found and no tubercle bacilli, the cystitis may really be of tubercular origin and the micro-organisms due to secondary infection.

As a rule, the cystoscope is better dispensed with. In severe cases with a narrow contracted bladder, it cannot be used with advantage; in milder cases it adds little to the diagnosis, and may bring about a secondary infection.

Local treatment, when carefully applied, is indicated in all cases. Properly conducted, it should not harm the patient. Instrumentation must be thoroughly aseptic; risk of secondary infection is great. Treatment should be applied from the beginning. Applied by lavage it is harmful, as distention of bladder increases pain and hematuria, and renders patient worse. The best method is by instillation, the fluid being applied drop by drop. The best agent is a watery solution of bichlorid, beginning with a strength of 1-10,000; 1-5000 being the limit of initial dosage. Applications may be made daily, the strength only very gradually increased, seldom passing 1-3000. A single application, too strong, may take some time for its effects to be overcome. Other drugs thus far have proved inferior, lactic acid, iodoform, and formol, the most promising, have proved disappointing. Guaiacol, twenty per cent. in sterilized oil, has proved of use in relieving the pain, but is not curative. Topical treatment should be continued a long time.

On entrance there was a large ecchymosis over right lumbar region and fracture of the twelfth rib on the left side, and severe localized pain. Patient urinated spontaneously, but only 100 grams of bloody urine.

During that day he passed no urine, had severe general pain over abdomen, and the abdominal muscles were strongly contracted, not allowing abdominal palpation. General condition bad, features drawn, eyes sunken. In the evening, passed a small amount of bloody urine.

Following day there was extreme sensitiveness of abdomen, which was distended; had had cramps in legs during night. Abdomen tympanitic except above pubes, where it was dull to percussion. Had not urinated; catheter withdrew 100 grams of urine and black blood. No vomiting. Was etherized, and a median incision made below the umbilicus; below the linea alba there was infiltration of blood passing down toward the symphysis. The peritoneum was not opened, but the wound disclosed an enormous cavity filled with two liters of urine mixed with blood. The pelvic peritoneum was found stripped up and rolled back, the exploring finger found the lateral walls of the cavity bounded by the pelvis and the obturator aponeurosis on each side could be felt. At the bottom of the wound the bladder was found, ruptured longitudinally from the summit to within one cm. of the neck. Edges of bladder wound were friable and ragged, and immediate suture could not be thought of. The cavity was washed out with boric solution, and by two or three sutures the edges of bladder wound were sutured to the abdominal wound and iodoform gauze packed between the bladder and the pelvic wall. Superior angle of abdominal wound was sutured by two or three deep silk sutures, and a syphon drain passed into bladder.

During the day vomiting; in the evening an intravenous injection, 800 grams of artificial serum, was made; pulse, 132. May 13th, 500 grams again injected, and May 14th, 600 grams again injected. A (de Pezzer) catheter was placed *à demeure*, and through it bladder was washed by boric acid.

May 18th, upper portion of wound united, the lower portion was infected. The silk sutures were removed. May 22d, chill and fever followed by a bronchopneumonia. The pelvic peritoneum gradually closed down.

From June 2d, delirium of sepsis set in and patient constantly removed his dressings and drain. From June 12th, improvement set in, and patient rapidly improved and left hospital August 24th. Passed his urine normally. Was seen in following November. Abdominal cicatrix in good condition, no impulse on cough. Patient then had pleurisy with effusion, but finally left hospital cured, the bladder acting normally.

Extraperitoneal rupture is relatively infrequent. Fenwick and Ulman, in their statistics, found it in 12 to 15 per cent. of the cases; Rivington, in 322 cases, only found 9 in which the rupture was extraperitoneal.

SYPHILIS.

Alterations of the Blood in Syphilis. JUSTUS (*Brit. Journ. of Derm.*, February and March, 1897).

Justus has made a special study of the anemia, well recognized as occurring early in syphilitic infection. He finds that the percentage of hemoglobin undergoes regular fluctuations commencing with the appearance of general glandular enlargement. It decreases slowly and steadily to its limit at the time of the secondary accidents. If the patient remains untreated, it increases to its normal level in health with their subsidence. Syphilis therefore destroys the hemoblobin which is built up again as the patient recovers spontaneously. With the administration, however, of a fairly large dose of mercury, the percentage drops immediately, to recover in a number of days proportionate to the virulence of the disease and the state of the patient. With every succeeding dose the drop is less marked until after a thorough course of mercurials the amount is greater than before the administration of the drug. The subsidence of the early accidents is coincident with the increase in resisting power of the hemoglobin, the disease itself causing temporary diminution of that power as regards mercury. . . . VALERIO (*Giorn. delle Malattie Ven. et delle Pelle*, 1896, p. 437) from a study of five cases reaches practically the results of Justus. He says that the alkalinity, density, and the chlorids in the blood are diminished in addition. As in previous researches, the author states that the globular resistance of the blood is proportionate to its richness in the chlorids of sodium and potassium. The biniodid of mercury, all things being equal, is more powerful in restoring the blood to its normal state than the protiodid.

Pigmentary Syphilide. D. FRATTALI (*Giorn. delle Mal. Ven. et delle Pelle*, 1896, p. 250).

The author examined a number of sections from the diseased areas with the following results:

(a) In the leucodermic portions, the epidermis is normal except for the presence of a great number of pigment granules in the basal cells of the stratum mucosum, and the existence of small masses of a dark amorphous substance between them. In the derma, particularly in papillary layer, zones of leucocytic infiltration were found about the papillary vascular loops.

(b) In the pigmented parts, the changes were almost identical save that the infiltration was not limited to the papillæ but spread more deeply. In addition to the leucocytes, there were seen other larger cells, round or polygonal, enclosing in their protoplasm tiny dark granules. Some of these resembled fixed connective-tissue cells, others presented a similarity to cells met with in the epidermic spaces.

The author concludes that the pigmentary syphilide is consecutive to a lesion of the derma consisting of a pericapillary infiltration of its upper layers. As in common syphilodermata, the dyschromia in this form has no other origin than the syphilitic infection.

Aneurism in Relation to Syphilis. G. ETIENNE (*Annals de Derm. et de Syph.*, 1897, p. 1).

In order to settle the point in what proportion syphilis is found in aneurismal patients, the author collected 2000 published cases, of which 240 were tabulated for study. Of the latter number 166, or 69 per cent., were syphilitic. Adding to them the cases of Malmsten, Welch, and Fraenckel (346 in all), the proportion was found to be 70 to 100, much too great for a mere coincidence. Following syphilis, as etiological factors, alcoholism occurred 28 times, malaria 8, rheumatism 7, typhoid fever 5, variola and pneumonia each 2; gout, scarlatina, dysentery, and erysipelas appearing once in 240 instances. Aneurism and syphilitic accidents, or incontestable signs of them, were found coincidentally 28 times (11 per cent). Curiously enough, aortic aneurism was found in husband and wife in two observations. All four were syphilitic. Syphilitic lesion of the vessel walls results in arteriosclerosis in plaques, eminently adapted to the development of sacculation of the trunk attacked, the change beginning in the vasa vasorum. The plaque determines the *locus minoris resistentiæ*. Clinical experience from many sources points to the same exciting cause. Amelioration under iodid is too well known, it seems, to need the extensive consideration given. Its rapidity is often astonishing. The length of the period between infection and appearance of aneurism, in 64 observations, varied from 11 months to 40 years, 10 cases developing in 1 to 5 years, 18, in 5 to 10, 10, in 10 to 15, etc. Speaking generally, aneurism occurs earlier in life when syphilis enters into its genesis, and in that disease, Jaccoud says aneurism is frequently multiple. The anatomical lesion is an arteritis beginning in any coat or a panarteritis involving them all. In the majority of cases, the histology does not differ from that of vessel disease in other conditions. Finally, the author thinks a large number of the cases are parasymphilitic.

Book Reviews.

Genito-Urinary Surgery and Venereal Diseases. J. WILLIAM WHITE, M.D., and EDWARD MARTIN, M.D. J. B. Lippincott Co., Philadelphia; 1897.

This book is conservative, learned, and is unquestionably needed for its admirable treatment of the surgery and diseases of the genito-urinary organs.

Though we have several works on venereal disease of great value, most of them cover a much narrower field, including, generally, only slight minor operations, leaving not only the major operations on these organs to works on general surgery, but also omitting important classes of cases, which are most apt to be seen first by the specialist, though he may not pretend to undertake the more critical operative procedures, for example, in tuberculosis and tumors of the genito-urinary tract, hypertrophy of the prostate, calculus, etc.

The andrologist has had little help in this direction from within his own ranks, outside of admirable (though scattered) monographs in current literature, and the last few years have shown such tremendous activity along so many lines that we believe this work to be most timely and the profession to owe the authors a debt of gratitude.

No work of this magnitude could be entirely free from disappointment, and we confess to a certain degree in reading the description of some of the operations, more especially those in which the authors have incorporated the writings of others. The latter, in some instances, are obscure and not easily understood by one not familiar with the operation, though they might be rendered clearer by turning to the original article. References, however, the authors have purposely, according to their statement in the preface, omitted, so far as the original articles are concerned, merely the name of the author being given. A desire to find them can, consequently, only be gratified after considerable search. It is this completeness of reference which gives immense value to the work on venereal diseases by R. W. Taylor. The omission injures, somewhat, the book's usefulness.

The authors, avoiding controversy, give mainly the consensus of opinion of the best writers. Personal bias naturally has its influence upon them in some instances, especially where they have identified themselves with a particular branch.

A glance at the table of contents occasions wonder at the arrangement of subjects, which we think could be improved. Beginning with diseases and injuries of the penis, and of the urethra, treating really of the surgery of these parts; gonorrhea and its complications are next considered, then chancroid and syphilis, and after disposing of these subjects diseases of the bladder are taken up. Then follow, in sequence, diseases of the genito-urinary tract. This involves a further description of the complications of gonorrheal disease under discussion of the diseases peculiar to each organ. Still, it is easy to find any subject one may desire, both from the table of contents and the excellent index.

The work is plentifully supplied with excellent illustrations, even to an X-ray reproduction of calculus of the pelvis of the kidney.

We cannot help feeling, after a perusal of some of the chapters, what a transitory state investigation is in at present in these lines, and how we must still look to the future for the solution of many problems.

The authors give an excellent chapter on cystoscopy and one on urinary analysis, which should always be an important chapter in works of this kind, but which is generally omitted. No mention is made in suprapubic cystotomy of the use of air in place of fluid for distention of the bladder. It deserves some notice, at least.

We could wish that in some instances etiology of disease were a little more fully treated; for instance, under varicocele. Although abdominal tumor and enlargement of certain viscera are mentioned as causes, the question is not brought out with the prominence it

deserves. The reviewer well remembers, as a student, a case of varicocele of large dimensions and rapid development seen by a learned professor who was promising a rapid cure when a quick-witted assistant called his attention to an abdominal growth lying in such a position as to be the probable cause.

We note in the treatment of gonorrhea the authors speak favorably of the Janet method. They emphasize the important rôle played by the prostate and seminal vesicles in the prolongation of this disease. In the chapter devoted to stricture, while not going to the extreme advocated by Otis, yet they acknowledge the great value of his work in the development of urethral and bladder surgery. The importance of great care in rendering aseptic urethral instruments is insisted upon, and a chapter is devoted to the care of them.

The well-known position of one of the authors as to the treatment of prostatic hypertrophy makes these chapters of special interest, and some attempt is made to classify the cases which may be expected to benefit from castration or vasectomy.

The treatment of syphilis forms an important chapter, clearly written, forcible, and authoritative. The last few years has shown little advance, as one may see from the similarity between this chapter and the well-known article by the same author in Morrow's "System." The work ends with a short, able chapter on Psychopathia Sexualis, sufficient to show a grasp of the subject and an avoidance of nauseous detail. This book will be of use to the student, the general practitioner, the surgeon, and the specialist.

G. K. S.

A Manual of Venereal Diseases. J. R. HAYDEN, M.D. Lea Bros. & Co.; 1896.

This little book of 260 pages is designed rather for the student than for the practitioner, though in it the latter will find many useful hints in the treatment of venereal disease.

The book is founded largely upon the work on venereal diseases by Professor R. W. Taylor, the main points of the latter being taken, while arguments pro and con, and the references by which that author makes his points, are necessarily omitted. In a work of this kind, however, we must expect to meet with statements to which we would take exception, and though the book will give one a good working knowledge as a basis for practice, it can give him no hint of the difficulties to be met or the problems still unsolved.

For instance, we read (page 15), "Although the majority of cases of gonorrhea are due to the gonococcus Neisser, yet there are some in which this pathogenic agent cannot be found, and we must therefore attribute the disease to other micro-organisms." Most specialists to-day confine the term gonorrhea to that form of urethritis in which gonococci are present; other forms of urethritis in which other micro-organisms occur, though they may have a venereal origin, are not looked upon as gonorrhea; they are comparatively rare, and when found are studied with interest.

Again, "Many men contract typical gonorrhea from women either during or immediately after the menstrual epoch, the women being free from gonorrhea." The reverse of this might be claimed with as much reason. Men pronounced free from gonorrhea by competent physicians, have married and infected their wives, the latter acquiring a typical gonorrhea. This has even occurred after a long period of married life, the man not being exposed to a fresh contagion. As a matter of fact, the menstrual epoch of a woman who has once had a gonorrhea is a dangerous period, even though no trace of the disease can be made evident by our present methods of examination. These cases are easily explained—much more easily than by claiming them to be free from gonorrhea. These women may be virtuous and true, but they are unquestionably unfortunate. To be capable of giving the disease, they must at some time—innocently it may be—have acquired the disease. The ease with which female children may acquire gonorrhea innocently is better understood to-day. The length of time that the human urethra may harbor gonococci, which lie there dormant and be still virulent to others, we do not know.

The treatment of gonorrhea here outlined is conservative and safe. Janet's method is not mentioned.

The author (page 24), outlining an abortive treatment, states that it should only be used during the first day or so of the disease, while the discharge is still *mucoïd* in character. Janet has stated that the earliest moment he has ever seen a gonorrheal discharge, that discharge has always been purulent. The experience of the reviewer is in accord with this.

It is rather surprising not to find a description of chronic prostatitis or chronic seminal vesiculitis, or their appropriate treatment; nor is there any description of the method of obtaining secretion from the prostate for examination.

In differentiation between chronic anterior and posterior urethritis, the author mentions the two-glass test, but does not mention how worthless it is under such circumstances, and how little to be relied upon unless accompanied by other tests.

Under chancroid, he mentions the Krefting-Ducrey bacillus, but says it has never been cultivated. It has been cultivated, but only on the human body. The author advises against cauterization of the chancroid unless there is positive indication.

In the treatment of syphilis he prefers the intermittent treatment.
G. K. S.

The Medical Gazette Publishing Co. of Cleveland, Ohio, announces a small volume soon to be issued with the title, "About Children." The author is Dr. Samuel W. Kelley, of the Cleveland College of Physicians and Surgeons. The book will contain six lectures filled with information for nurses, medical practitioners, students, and all who have the care of children. Advance orders will be filled in September.

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Original Communications.

THE CONNECTION OF TUBERCULOSIS WITH DISEASES OF THE SKIN OTHER THAN LUPUS VULGARIS.

OPENING OF THE DISCUSSION BEFORE THE THIRD INTERNATIONAL
CONGRESS OF DERMATOLOGY IN LONDON, THURSDAY, AUGUST 6,
1896.

By JAMES NEVINS HYDE, M.D.,

Professor of Skin and Venereal Diseases, Rush Medical College, Chicago.

MR. PRESIDENT AND GENTLEMEN OF THE CONGRESS:

In opening the discussion appointed for to-day upon the connection of tuberculosis with disease of the skin other than lupus vulgaris, it will be barely possible in the time allotted to make more than a brief survey of the general subject. It is proper, however, at the outset, to take advantage of the opportunity offered to acknowledge indebtedness, in this connection, to our distinguished colleagues, Messrs. Riehl, Paltauf, Chiari, Unna, Hallopeau, Doutrelepont, Morris, Crocker, Morrow, White, and many others.

It must be admitted, however, that we are in ignorance of a great part of the field covered by the subject under discussion, and that even in the portions most exhaustively studied our knowledge is far from satisfactory. Aside from lupus vulgaris it is established that primary infection of the skin with tubercle bacilli occurs, and that this may be followed by a secondary infection of other organs of the body. It is also admitted that a visceral tuberculosis, primary in origin, may be followed by a secondary infection of the integument. But, further, inasmuch as tubercle bacilli are demonstrated to be capable of transference both by auto-inoculation and by transport by the medium of the leucocytes through the lymphatic vascular

channels from one portion of the skin to another, it is necessary to recognize the possibility of occurrence of another class of secondary tuberculous infections of the integument, as for example, where a primary tuberculous infection of the skin of the face is followed at a later date by a secondary cutaneous infection of another region of the bodily surface, such as the skin of the shoulder or of one of the lower limbs. Not a few of these instances are on record. Lastly, it must be conceded that a tuberculosis of one or more of the viscera of the body may be at times responsible for a cutaneous exanthem whose lesions, though not themselves containing either bacilli or the toxins of such micro-organisms, may yet be reflex or associated symptoms of such infection.

Looking first to the clinical symptoms of cutaneous tuberculosis, excluding lupus vulgaris, their diversity and disparity are conspicuous. There is but little outward likeness between a bean-sized tuberculous wart on the finger and a group of gigantic ulcerations covering one-fourth of the area of the trunk. These differences are generally explicable: (1) by the striking fact that the number of tubercle bacilli demonstrable in different lesions is subject to a very wide variation; (2) by the fact of the great diversity among the soils upon which the germ is implanted, or, in other words, the tissues of infected individuals; (3) by the fact of variations in the exposures to which the several regions of the body are subjected after infection, seeing that, for example, the exposures of the infected face are widely divergent from those of the infected hand.

In attempting to classify these infective phenomena, even for temporary purposes, it may be convenient to divide them into three categories, separable by a line which must necessarily change with every advance of our knowledge of the subject. The first category includes a list of lesions which, by the most of experts, are accepted as directly connected with either a primary or secondary tuberculosis of the skin. The second includes a series of lesions with respect to which, in each instance, it has not been demonstrated that tuberculosis is directly responsible for the result, but where the indirect proofs are conspicuous, and where it is reasonable to expect that at no distant date the demonstration may be satisfactory, at least with some of the individual members of the group. By the phrase "indirect proofs," reference is made to cases in which, even though the presence of tubercle bacilli has not been demonstrated in cutaneous lesions, or in a few and rare cases has been so demonstrated, transmission to the lower animals has been followed by death from tuberculosis; and also cases where microscopical exami-

nation of tissue has brought into view the classical signs of tuberculosis, apart from the discovery of bacilli, such as recognition of necrotic tubercles, giant cells, epithelioid cells, etc.

A third category should include the dermatoses occurring symptomatically in connection with a visceral tuberculosis, where it is neither probable nor presumable that bacilli are present in the elementary lesions.

With respect to the first-class, *viz.*: that inclusive of the disorders of the integument, where tubercle bacilli have been demonstrated to be the effective cause, an effort to enumerate the individual members of the group is at once confronted with a possible source of error. One or several of the manifold phases of lupus vulgaris, which by the terms of this discussion should be excluded from the category, are exceedingly likely, under different designations to find their way into the list.

There are, in all languages, more than one hundred different terms applied to the disease to which the name lupus is now restricted. In the appended list, therefore, it will not be remarkable if it be discovered that some of the titles may have been relegated by authors to the category of varieties of lupus vulgaris.

Verruca Necrogenica (anatomical tubercle, post-mortem wart) is to-day generally admitted to be due to primary infection of the skin, and usually of the papillary layer of the cutis. The papule or papulopustule, having a warty summit, which occurs at the site of infection, is quite characteristic in consequence of its horny cap, and generally recognized without difficulty by the clinician.

Tuberculosis Verrucosa Cutis (Riehl and Paltauf), *lupus scléreux* (Vidal, Leloir), *lupus papillosus* (Neisser, Doutrelepon), is to-day an accepted and classical type of cutaneous tuberculosis, for the expert requiring no description. Here, also, the papillary layer of the skin is chiefly involved. In its purity this symptom of cutaneous tuberculosis is seen on the flexor aspect of the lower forearm (a site of ready inoculation) and also on the lower extremities within a short distance of the integument covering the inner malleolus. The elevated ovoid plaques found in these and other situations are usually covered with fine vegetations, minute pustules, and thin crusts.

Tuberculosis Papillomatosa Cutis (Morrow, Brissaud, Gilbert, Arrinot) is by some authors assigned to the category of verrucous tuberculosis described above. In these rare cases, however, marked clinical differences are conspicuous in the exuberant, florid, soft, and irregular excrescences rising to the height

of one and even two centimeters, closely packed together, but with individual elements separable by deep fissures, the whole smeared with a puriform mucus occasionally concreting into dark-colored crusts.

Fibromatosis Tuberculosa Cutis (Riehl).—By this term are designated the papillomatous and even sclerotic growths of tuberculous origin occasionally found near the mucous outlets of the body (nose, anus, etc.), but also on the lips and cheek. The fibromatous lesions are usually small and interspersed with verrucous vegetations and small shallow ulcers. The lesions may be in the form either of projecting tumor-like bodies or of thickenings of the deep subcutaneous tissue.

Elephantiasis Tuberculosa Cutis is a term applied to gigantic overgrowths of the integument usually complicated by lymphatic occlusion. In these cases there has usually been a blocking up of the lymph-channels by an infarction produced by leucocytes charged with tubercle bacilli.

Tuberculosis Cutis Ulcerativa. (The tuberculous ulcer.) (Chiari, Riehl).—The lesions included under this title were, as is well known, once thought to be the chief primary tubercloses of the skin. The excavated ulcers, however, forming near the mucous outlets of the body with irregular and undermined edges, loosely attached borders, and occasional crusts, are usually associated with a visceral tuberculosis or with lesions involving the mucous membrane of the mouth or of the vaginal or rectal walls.

Tuberculosis Gummatosa Ulcerativa. (Cutaneous scrofuloderin; subcutaneous scrofuloderin, tubercular cutaneous fistula).—Under these titles are included the rather common forms of tuberculous involvement of the skin following the formation and especially the bursting of a subcutaneous scrofulous gumma involving the lymphatic glands. The resulting irregularly outlined ulcers, with thin livid edges and purplish halo, often studded with miliary tubercles, and the concomitant symptoms of chronic keratitis, of disorders of the menstrual function in women, and in severe cases of involvement of the abdominal glands, furnish a sufficiently common clinical picture.

Lymphangitis Tuberculosa Cutanea (Besnier, Lejars).—The lymphatic vessels of the skin may be primarily or secondarily invaded with tuberculosis, resulting in the production of either linear lesions corresponding to the lymphatic trunks or of tuberculous nodules or warts, dermic or subcutaneous in situation, which eventually ulcerate and discharge pus, blood, or lymph. These cases

are rare. At times a reticular network is formed leading to bone. Several of the lymphangiectases have been demonstrated to be tuberculous.

Tuberculosis Cutis Serpiginosa Ulcerativa.—This term relates to a rare and interesting group of lesions in which brownish-red nodules, varying in size from a pea to a bean, degenerate in the course of weeks or months and result in centrifugally spreading, oval or roundish, at times even horseshoe-shaped ulcers, grayish-yellow in hue, or hemorrhagic and interspersed with cicatrices. The resemblance of the involved patch to a tuberculous serpiginous syphiloderm may be striking. Instead of nodule-production, the first stage may be that of circumscribed infiltration. The area of involvement may be limited or may be extend over large regions of the body surface. At times secondary foci form at a distance from the original site of infection, at other times visceral, and especially pulmonary tuberculosis, may follow. The process seems to bear no relation to the evolution of a scrofulous gumma.

Tuberculosis Cutis Fungosa (Riehl).—Under this title are included the tumors resembling those occurring in mycosis fungoides secondarily infected with tuberculosis from other and often adjacent organs such as muscle, bone, etc., the reddish-brown nodules originally formed, increasing at first to the size of a hen's egg. These may surmount large areas of infiltration and ulceration, exhibiting beside the tumors, minute pustules, vegetations, and crusts. Eventually typical tuberculous ulcers form.

Tuberculosis Nodosa Atrophica (Ransom and Van Gieson; Hyde).—In the rare cases to which attention is called by this title, millet-seed-sized papules develop with great slowness and in appearance strongly resemble the nodules of lupus vulgaris. They commonly develop in a single well-defined patch, not larger than the transverse section of a pullet's egg. The papules do not have a tendency to undergo ulceration, and while a few may contain an "apple-jelly" like substance, others, when punctured, seem vacuolated. The last-described lesions, and possibly, also, the others may recede, leaving minute pits or depressions in the skin, the skin between the minute nodules constituting, for the most part, the center of the patch, exhibits a scar-like area of dead-whitish hue. It is not certain that the atrophic cicatriform patches have been preceded by tuberculous nodules. In the sections made in the case reported by Messrs. Ransom and Van Gieson the lesions were found to be superficially situated and minute vesicles had formed as a consequence of effusion from tubercular foci beneath. In their case as well as

in my own (portraits of both are here¹ shown) the tuberculous character of the process was recognized by the microscope and by inoculation of guinea-pigs, which later died with marked evidence of tuberculosis not merely in the glands but in foci at the point of inoculation.

Upon the second group of cases, those, *viz.*: where tubercle bacilli are probably present in some lesions, at least, in small number, or have in a few instances been recognized, but where actual demonstration of them, however, at the moment is lacking, one is justified in speaking with great reserve. The indirect proofs already suggested in these pages are in some of these instances striking, and not to be ignored. In others, it is possible that further study may remove the names of a few disorders to another list.

Erythema Induratum Scrofulosorum (Bazin).—Tuberculosis has been demonstrated in a few instances of this affection, where multiple subcutaneous infiltrations, usually discrete and of a livid-red hue, have degenerated into ulceration. The resemblance to syphilitic gummata, which have burst, is striking. These cases, as is well-known, occur, for the most part, in young subjects of the female sex, who are affected with struma and have been engaged in standing upon the feet for long periods of time, the lesions appearing upon the lower extremities.

Lupus Erythematosus.—The histopathological differences between tuberculosis of the skin and erythematous lupus are so significant that if the question of the relation between the two diseases were to be decided by the microscope alone the answer would be prompt, and categorically in the negative. The very few instances in which tubercle bacilli have been discovered in erythematous lupus have probably been exceeded in number by the others in which the same micro-organisms have been recognized in acne pustules and a few other non-tuberculous affections.

At the same time it is impossible to deny that erythematous lupus occurs in tuberculous patients and with a relation to the systemic disease more intimate than if these infected individuals simultaneously exhibited either an alopecia pityrodes or a zoster. There are probably none present who have not observed these coincidences. My distinguished colleague from France, who takes part in this discussion, has published reports of cases in which patches of erythematous lupus existed on the persons of patients dying with systemic tuberculosis, and I have observed precisely similar cases—one during the last year.

Even when the term lupus erythematosus has been correctly ap-

plied to a skin affection, it is, of course, erroneous to suppose that such a term designates a disorder of fixed limitations and unique type. As our knowledge extends we are daily discriminating between the wide variations displayed in the scaling and atrophic varieties, and the florid, vascularized types assimilated in external appearance to some of the forms of lupus vulgaris. It is within the bounds of probability that at no distant day some of the clinical forms at present regarded as lupus erythematosus may be classified under a different title.

No clinician of experience has failed to note the occurrence of cases in which intermediate forms exist between types of lupus vulgaris and of lupus erythematosus. Even in the absence of clinical experience there are few observers who, in examining the plates published, with a view to illustration of the diseases, may not at times mistake the one for the other. It is, therefore, to be accepted, that: (*a*) the patches of erythematous lupus do not originate in primary tuberculous infection, exhibit no histological features of the plasmoma of tuberculosis of the skin and furnish no infective material for a possible secondary tuberculous infection; (*b*) erythematous lupus occurs in nontuberculous patients as a result of etiological factors as yet undetermined; (*c*) erythematous lupus occurs in the subjects of tuberculosis, when it is highly probable that the systemic state is largely responsible for the cutaneous disorder.

Lichen Scrofulosorum (acne cachecticorum, folliculitis scrofulosorum).—These titles represent a group of disorders the individual members of which vary slightly each from another. In the type for the recognition of which we are indebted to the Vienna school, the papules or variants, in the form of papulopustules, are millet-seed-sized, grouped in circles, or portions of circles, and occur for the most part over the abdominal region, but also on the sides of the trunk. Often they are covered with a minute scale. The follicular, or acneiform, type of the disorders represented in the group, occurs with symptoms predominantly displayed over the face, the shoulders, and especially the lower extremities, where the primary lesions may be larger and interspersed with fine scales and giant comedones.

Jacobi, H. Hebra, Hallopeau, and Sack have demonstrated the presence of sparse tubercle bacilli in some of these cases, and the disorder is by many accepted as one of the tuberculoses of the skin. Others, however, agree with Kaposi that it is merely an exanthem of the scrofulous; yet others argue in favor of a mixed infection. I feel confident that the disease is not as yet properly classified with

the tuberculososes proper of the skin; but that it is a dermatosis of the cachectic and chiefly of the scrofulous. As the disease is rarer in America than elsewhere, I show a drawing representing the American type of the affection on the leg of a young woman suffering at the same time from multiple scrofulous abscesses of the lymphatic glands of the neck, of the axillæ, and of the breast. On the lower extremities the disease was displayed symmetrically.

Tuberculosis Suppurativa et Bullosa Acuta (*Forme suppurative et pemphigoïde, tuberculose cutanée*. Hallopeau, Wickham).—In the rare cases described by this title, deep, circumscribed infiltrations of the skin result from the coalescence of isolated and aggregated minute pustules, pale-reddish in hue, seated on an engorged base. There is an areola about each, the entire patch showing a pemphigoid elevation at the spreading peripheral border, which can be recognized as divisible into separable masses. Many of the millet-seed-sized pustules are seated at the orifices of the pilo-sebaceous orifices.

Both in evolution and involution the patches exhibit acute transformations; in a single area may be studied at one moment the peripheral bullous wall, sprinkled with small pustules, while centric decolorization of the patch is in progress and subsidence of the swelling. The relation of this disorder to lichen scrofulosorum has yet to be decided.

Acneiform Tuberculosis of the Facial Integument.—This is a rare disorder, and one which perhaps has been mistaken at times for a simple acne. The subjects of the affection are usually young women with a history of tuberculosis in other members of the same family, affording thus ample opportunity for infection of the skin of the face through the medium of the fingers.

The disease originates by tuberculous infection of the lesions of acne. As the morbid process advances there is usually auto-infection of the skin of the face at several points, but as a rule the greatest activity of the process is displayed at not more than one or, at the most, two points of the face at the same time.

The face is the usual seat of this disorder, both sides of which are involved, but usually with asymmetry. The lesions first succeeding those of simple acne are firm, light, or dark reddish, elevated papules which degenerate by suppuration and by a species of dry resolution, leaving pin-head or pea-sized, sharply defined, conical or funnel-shaped ulcers. Scarring results, the resolutive lesions being succeeded by broad, thin, whitish, deforming cicatrices of an area apparently broader than that of the original lesion. The ulcers

which result from the degenerating papulopustules penetrate below the skin to the subcutaneous tissue, especially near the root of the nose and the inner canthus of the eye, where, through a funnel-shaped orifice, can be distinguished the smooth and pallid walls of an excavation secreting a thin seropus. The ulcers heal with the production of ridged and corded scars. The disorder is exceedingly chronic in its course, and in the few cases observed seems to have failed of producing secondary systemic infection. Its tuberculous character has been chiefly demonstrated by infection of the lower animals with tuberculosis.

Sycosiform Tuberculosis of the Skin (Lupoid sycosis, Robinson) chiefly affecting the face of male patients, strongly suggests in many of its features the lesions last named. It results from infection of a hyphogenous, or more commonly coccogenous, sycosis with tuberculous material.

The lesions are often multiple and asymmetrical, but occur on both sides of the chin and bearded cheek. They develop primarily as papules, which more often undergo dry resolution with scarring than superficial or deep ulceration. When the redness which characterizes the development of each nodule or agglomerated group of nodules has disappeared, there is usually left a series of depressed cicatriform furrows often lying between equally elevated cords and ridges of the integument at times wholly or in part deprived of hairs.

Evidence of the tuberculous nature of this process rests upon the grounds last described.

Folliculitis Tuberculosa. (Suppurating agminated perifolliculitis. Quinquaud.)—A group of disorders but little understood and scarcely differentiated from other affections (*e. g.*, lichen scrofulosorum, acne cachecticorum) is to be recognized in the pilosebaceous organs, in regions covered by lanugo-hairs and over hairy scalp after primary infection of the follicles with tuberculous material, probably through the medium of the fingers. The cases heretofore noted have generally been instances of infection of the hair-follicles. The disease is characterized by the production of firm elevations of the surface, usually at several points simultaneously, but with marked predominance of one or two significant lesions on the scalp. These furnish a glairy, viscid, semitransparent secretion which escapes from pockets formed in the subcutaneous tissue. Occasionally, but rarely, there is suppuration. The disorder is exceedingly indolent in its career, and eventually there is left at each deeply involved point, a densely corded ridge often

without hairs but at times with wisps of hairs in islands projecting irregularly from the sides and at the bases of the ridge, where also there is usually furnished a thin secretion. The affection in some of its features bears a striking resemblance to the dermatitis papillaris capillitii of Kaposi. The disease may coexist with pulmonary tuberculosis. It may originate from a deep-seated tubercular focus or may be productive of the latter.

Keloid.—Histological examination discloses no suggestive resemblance between the tissue of keloid and of a tuberculous wart. The perivascular fibromatous mass of keloid with collagenous bundles arranged in regularly paralleled fibers, certainly bears no relation to the softer and more deeply situated nodule lying in a mass of closely packed cubical and giant cells, whence the collagenous material has been almost completely removed.

At the same time there are facts not to be ignored pointing to a relation in certain cases between the production of keloid and of tuberculosis. The two affections are exceedingly common in the negro. The recurrence of keloid after extirpation is not satisfactorily explained by studies in the histological laboratory. The origin of many masses of keloid of moderate size at the site of the lesions of lepra, lupus, acne, syphilis, and certain of the medicamentous rashes is a significant clinical fact.

I have produced tuberculosis in guinea-pigs after inoculation with keloid tissue; and in a very few cases tubercle bacilli have been recognized in the connective-tissue cells of the smaller tumors.

Ulcus molle of the groin especially, after the bursting of a chancroidal bubo, and when persisting for months, has long been regarded as a symptom of struma: In rare cases (Schraeder, Quinquaud) the extensive destruction wrought subcutaneously in the skin of the thigh and of the abdomen has lent color to the supposition that tubercle bacilli have been implanted upon the chancroidal sore. Doutrelepon, Quinquaud and others have demonstrated that this accident occurs. A striking example of this condition was lately exhibited in my clinic.

In the third and last of the several groups described above are the titles of a few disorders for which it is not claimed that they are due primarily to the presence of tubercle bacilli or to a tuberculous toxin, but merely that they occur in tuberculous subjects, and may be at times a localized expression of the systemic state. However indeterminate may be the boundaries of such a group the disorders named are worthy at least of mention in this connection, even if only from the point of view of the clinician.

Eczematoid patches of lichenoid type, fixed in situation, persistent in course, and rebellious to treatment occur in persons having a scrofulotuberculous history where the lesions of lichen scrofulosorum are interspersed over nummular areas. Instances of this are reported by Gastou and others. The *névrodermites* of French authors are also occasionally recognized in persons of a strumous constitution. Some of the genital eczemas due to glycosuria have a remote origin in tuberculosis of the kidney.

Erythema pernio (chilblains) is an affection recognized in the tuberculous as often as the erythema induratum of Bazin. The feebleness of the local circulation in cases is due to tuberculosis of the respiratory tract. Leslie Roberts (quoted by Crocker) is responsible for the statement that injections of tuberculin may exert an influence in the same direction.

Erythema multiforme is at times an expression of a cachexia due to the tuberculous state. The melanodermata, whether diffuse and general as in Addison's disease, or circumscribed as in the forms described by Guéneau de Mussy, have so obvious a relation with tuberculosis of the viscera as merely to require mention in this connection. The same remark applies to some of the varieties of scorbutic purpura.

Lastly, there are a number of *drug eruptions* which occur chiefly on the persons of those debilitated by a tuberculous cachexia. As an example may be named the rare bullous dermatitis following the internal administration of the potassic iodid.

TUBERCULAR NECROSIS OF THE PROSTATE.¹

By EUGENE FULLER, M.D.,

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TUBERCULOSIS in connection with the prostate is spoken of in most text-books as of common occurrence. If one, however, reads these books carefully it will be seen that the term prostate is used very loosely and unscientifically, it being made to include besides the prostate proper the neck of the bladder, the deep urethra and the seminal vesicles together with their ducts. If the text-books had said that tuberculosis in connection with the deep urethra and the genital tract is of common occurrence they

¹Read before the Section on Genito-Urinary Surgery at the Congress of American Physicians and Surgeons, Washington, D.C., May 6, 1897.

would be correct. As it is, however, they are incorrect since tuberculosis of the prostate is of rare occurrence. In the common disease, tuberculosis in connection with the seminal vesicles, the natural loose connective tissue enveloping the sacs becomes infiltrated with a hard inflammatory exudate, which appears to the finger-tip introduced into the rectum as a firm tumor of considerable size. The surgeon on feeling such a mass almost invariably pronounces it prostatic enlargement. He does this without any special thought, since from his teaching he has been led to consider any tumefaction felt in this region to be "prostatic." If, however, a dissection be made in a case of this description, and I have done it on several occasions, the prostate itself will in most instances be found normal although encased, as it were, in the inflammatory exudate which has been thrown out about the diseased seminal vesicles and which has extended itself into the meshwork of the fibrous structure forming the capsule of the prostate. Tuberculosis in connection with the deep urethra tends to extend itself along the ejaculatory ducts and into the seminal vesicles rather than into the prostate. Still, in cases where tubercular ulceration of the prostatic urethra occurs the portion of the gland lying next the urethra becomes secondarily involved by the ulcerative process which may, and rarely does, extend so as eventually to cause its total destruction. Very infrequently tuberculosis may attack the prostatic body primarily and independently of the deep urethra or the genital tract. During my last winter service at the City Hospital I encountered one, and in all probability two such cases. In neither of these cases were small foci of tubercular deposit found disseminated throughout the living tissues of the organ, but in one of them a focus of necrosis the size of a marble marked the area of infection in a prostate otherwise normal, while in the other the entire prostate was in a condition of necrosis. The following is a description of the two cases:

CASE I.—A man about thirty-five years of age entered my service at the City Hospital with a history of having had syphilis. He was emaciated. His throat presented evidences such as often remain after late syphilitic lesions. His lungs showed signs of phthisis. He complained of no genito-urinary symptoms. He soon became mentally clouded and after a short interval died. At autopsy his lungs were found to be extensively tuberculous. In the substance of the prostatic body and entirely surrounded by prostatic tissue an area of necrosis the size of a marble was discovered on making a cross-section of that organ. The limits showing the extent of the necrosis were well marked, the area being distinctly grayish in color.

Microscopical examination made by Dr. Blanchard, pathologist to the City Hospital, showed the spot to be one of tubercular necrosis. The rest of the gland was normal, as was the deep urethra and the seminal apparatus. The gland itself was not appreciably enlarged and before a cross-section had been made there was nothing in the general appearances to lead one to suspect the existence of anything abnormal. In making a cross-section of the brain a similar, although somewhat smaller, area of necrosis was discovered in the cerebellum.

CASE II.—A negro, forty-five years of age. A year before had weighed 190 pounds. Present weight 140. Very weak and debilitated. His special complaint was an inability to urinate. This difficulty had gradually developed, becoming first noticeable about eight months previously. He then discovered that he was called upon to urinate more often than normal and that he passed little at a time. Heretofore his stream had always been free and natural. During the early stages of his trouble he stated that what urine he did pass was clear and free from pus. There was also no pain or evidence of urethral or vesical inflammation at that time. His difficulty in urination increased rapidly and about five months previously he had found himself in a state of complete retention. At that time a catheter was passed without difficulty and a large amount of urine evacuated. He was then told that he was suffering from prostatic hypertrophy. Dating from the retention and the use of the catheter his painful vesical symptoms commenced and after that he failed rapidly. His urine, so he stated, began from then on to smell badly and to be very thick. Tenesmus associated with hypogastric and perineal pains developed. He was forced to depend upon a catheter. Before entering the City Hospital he had already been in two hospitals, where the treatment had been catheterization and vesical lavage, all to no purpose. On examination, I found on introducing my finger into the rectum a large, hard, prostatic tumefaction, but slightly sensitive and resembling to the feel a case of senile hypertrophy in a state of moderate inflammation. Back of this I could make out both seminal vesicles, which appeared thick, indurated and imbedded in a mass of perivesicular inflammation. One testicle was also enlarged and indurated, the seat of an inflammatory process. The urine as drawn by the catheter was loaded with pus and foul. It contained also a large amount of albumen. Abdominal palpation revealed considerable tenderness over the right kidney and a moderate amount over the left. There was no evidence of stricture. It seemed from the history that the primary cause of trouble had been urinary obstruction due to some pathological enlargement of the prostate, and then

that secondarily the bladder had become infected from catheterization, which infection had gradually ascended to the renal pelvis. In the absence of any evidence to the contrary, I suspected also that the inflammatory condition of the seminal vesicles was subsequent to the catheterization. I did not believe that the enlargement of the prostate was due to senile hypertrophy, as his age as well as his race were against that idea. It would doubtless have been well to have made a bacteriological examination of the urine for diagnostic purposes. The condition of the patient, however, when first seen by me was desperate and it was evident that vesical drainage established without delay was indicated. I performed accordingly perineal section. On cutting through the prostatic mass a small amount of very foul pus escaped, and to the finger introduced into the wound the cut section of that organ felt unctious and slippery, something like the surface of a piece of parboiled soap. On separating and withdrawing a piece of it, I discovered that the peculiar feel was due to a condition of necrosis. I then removed without difficulty in several sections almost the entire gland, all of which was completely necrosed. The structure of the gland, however, was in a state of perfect preservation except in the region of the periphery, where a process of ichorous deliquescence was taking place, due to the efforts of Nature to form a line of demarcation. The necrosed tissue removed proved to be tubercular. The patient died about twelve hours after the operation and an autopsy was obtained. The entire prostate was found to have been involved by the necrosis. The inner layer of the prostatic fibrous capsule was lined with granulations, showing that Nature had detached the dead from the living tissues. The prostatic urethra and the neck of the bladder, aside from showing evidences of surface inflammation, were normal. The mucous membranous surface of the bladder was congested and inflamed. Both seminal vesicles were filled with purulent material and one of these showed evidences of ulceration in connection with its mucous surface. The area of prostatic necrosis was widely separated from the seminal vesicles. One testicle showed tubercular evidences. Double purulent pyelitis existed, although this seemed of a fairly recent date as there were no ulcerative changes. From the *post-mortem* it seemed evident that the pathological process in connection with the prostate was the chief and original one as far as pertained to the genito-urinary organs. So it was also that the autopsy tended strongly to confirm the evidence derived from the clinical history, which pointed directly to the prostate as the first cause for complaint.

I think it most probable that the tubercular prostatic process in

Case II. was similar to that found in Case I., and that had Case II. been examined in an earlier stage of disease an appearance similar to that described in Case I. would have been discovered.

In Case I. the tubercular prostatic focus the size of a marble occasioned no subjective symptoms, the pathological condition being first suspected and discovered at autopsy. From the history in Case II. it seems probable also that the early stages of the prostatic necrosis gave rise to no symptoms. In fact I am inclined to think that no symptoms were observed in the second case until Nature made the attempt by the formation of a line of demarcation to separate the dead from the living tissue. At that time the inflammatory engorgement in connection with the fibrous tissues encircling the prostate caused in all probability a tumefaction sufficient to occasion the retention which began five months previously.

I have not been able to find recorded another case similar to my Case II., although I have no doubt that other such cases exist, especially as Case I. seems to represent an early stage of the same disease. In all probability some cases classed as prostatic abscess have really represented this condition. It is most important, however, to differentiate between the two since the prognosis of prostatic abscess ought to be good, while that of tubercular necrosis of the prostate is the opposite. In differentiating between the two conditions, the insidious commencement, the absence of acute inflammatory symptoms and the evidence of tubercle elsewhere, ought to be sufficient to distinguish the tubercular from the acute process.

It is not improbable that resolution may occur in instances of tubercular necrosis of the prostate, especially if the area involved be not very extensive, in which event it is to be expected that one of two things should happen: First, that the disease should become encysted, leaving a spot of fibrous tissue infiltrated with lime salts, or second, that the mass should deliquesce and finally break through its cavity into the urinary tract or bowel. I have in mind a case which came to my notice a number of years ago while associated with Dr. Keyes, which might well represent a recovery from this condition. The patient, a man of about fifty years of age, had for years suffered from frequent and urgent urination, together with an inability to empty his bladder entirely. His urine contained pus. A perineal section was performed and on cutting through the prostate, which seemed enlarged, a cavity the size of a pigeon's egg was found occupying what seemed to be the central portion of the prostatic body. The walls of this cavity were lined with velvety granulations, adherent to which in places were numerous phosphatic

calculi. The cavity communicated apparently with the prostatic urethra. It was curetted and packed with gauze. The patient in large measure recovered from his urinary difficulties as a result of the operation. A year or so afterward, however, he again appeared, this time suffering from a tubercular testicle. It is easy for me now to imagine that the cavity found in his prostate had originally been filled with a mass of tubercular necrosis, which had deliquesced and discharged itself through the prostatic urethra. In fact, it is hard to account for it in any other way.

STRONG SOLUTIONS OF THE ICHTHYOL GROUP IN ACUTE AND CHRONIC INFLAMMATORY CONDITIONS OF THE SKIN.¹

By HERMANN G. KLOTZ, M.D.,
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WITHIN the last three or four years I have extensively employed ichthyol, thiol, and, in a more limited way, tumenol, under circumstances and in a manner somewhat at variance with the usual teachings of the authors. Having generally obtained satisfactory results I feel justified in submitting to you a brief report on my experience.

Among the drugs mentioned the ichthyo-sulphate of ammonia, or ichthyol, is the best known, thanks to Unna's studies. Although I have not found the smell of ichthyol so serious an obstacle to its employment as, for instance, Crocker, I have recently given more attention to the almost odorless thiol, a synthetic product claimed to be chemically identical with ichthyol. It is sold as liquid thiol, a forty-per-cent. solution, at a price differing not much from that of ichthyol. I have found it about equally effective so that the absence of the odor is its only advantage. Tumenol, which contains no sulphur, but according to Neisser, its principal sponsor, exhibits the same "reducing" influences as ichthyol, is less serviceable because not so easily soluble in water. I have used almost exclusively in chronic cases the "tincture" recommended by Neisser, a ten-per-cent. solution in equal parts of water, alcohol, and ether, and occasionally the deposit which forms at the bottom of the vessel if the tincture is not shaken up for some time. The influence which these drugs exert on the skin is attributed by Unna, and commonly so accepted by the authors, to their "reducing" powers, that is, to the power of withdrawing oxygen from the tissues, which manifests

¹ Read before the Am. Dermatol. Association, Washington, May, 1897.

itself by influencing the process of cornification and by contraction of the blood-vessels. The strong antiparasitic properties of ichthyol have been demonstrated by Fessler and Abel; they are equally claimed for thiol but not for tumenol. One excellent quality, common to the three drugs, is hardly mentioned, certainly nowhere emphasized, neither by Unna nor by other authors, namely, that spread in a thin layer either pure or mixed with equal parts of water or in other strong solutions ichthyol and thiol, and, in the above-mentioned tincture, tumenol dry quite rapidly leaving a very fine, non-contracting film as a cover on the surface. At a temperature of 68° F. I found the skin dry two minutes after being painted with those solutions, that is, if touched with the finger no stain was produced nor a distinct sensation of adhesion. The advantages of this film formation are at once apparent; incidentally to the effect of the drug itself we obtain first the cooling due to rapid evaporation, and second, exclusion of the air and other irritants from the affected portions of the skin without the need of further dressings or bandaging. As to ichthyol and thiol it is particularly opportune that this covering film can easily be removed with water, a great advantage over applications of collodium and traumaticin. Tumenol is not affected by water and for that reason was found useful in localities exposed to moisture; as, for instance, the glans penis near the urethral orifice. It is true that the high temperature and often moist atmosphere of our summer weather are not so favorable to the rapid drying of the solutions, but that holds equally good for all similar preparations like the gelatins, plasment, etc. In such instances it is advisable to dust the painted surface with some indifferent powder. I have found the stearate of zinc and its combinations applied with the pulverflator quite appropriate for the purpose. Or a very thin layer of absorbent cotton may be spread over the parts and allowed to stick, particularly on a moist or oozing surface.

The application of these stronger solutions is by no means a new device. It was recommended and commented on together with the limitations of its usefulness by Unna in his monograph on ichthyol and resorcin in 1886, to which we are indebted for the largest share of our knowledge of the therapeutic value of ichthyol in skin diseases. In fact, the rather voluminous literature on the drug has added very little of importance to the rules laid down by Unna, but seems to have lost sight of some valuable points. With few exceptions the authors advise the application of comparatively mild ointments and solutions only, and some consider ichthyol as rather dangerous and irritating in many individuals. I have no doubt that as with almost

every drug cases of idiosyncrasy will be found, but I have not met with any case of pronounced intolerance against ichthyol and thiol, although I have had frequently occasion in cases of epididymitis to use twenty- and twenty-five-per-cent. ointments on the skin of the scrotum, a usually rather tender and sensitive locality. It seems, besides, that spurious preparations of the drug have occasionally been the cause of unfavorable results. Such an experience has been reported by Hartmann.¹ He treated very successfully with solutions of ichthyol in gradually increasing strength a series of cases of ulcers of the leg. A second series treated in the same manner with a preparation obtained from a different source all proved failures. Finally he procured ichthyol from a reliable house and again the treatment was successful.

I am, however, far from advising the general and indiscriminate use of the stronger solutions, but want it to be understood quite distinctly that those only should try them who are well acquainted already with the treatment of skin diseases and with the capriciousness of that organ in its reaction on drugs in general. The application itself ought never be left to the patient but be made invariably by the physician himself.

As it is the case with the "reducing" drugs in general, the action of ichthyol, to which alone as the principal representative I shall mostly refer for the sake of briefness, greatly differs when applied in mild combinations or in strong ones; in fact, strong doses may produce the very same condition which mild ones may readily cure. But much again depends on the duration of the action and on the frequency with which it is repeated. Long-continued applications of mild solutions are liable to irritate and cause increase of inflammation, while a single application of a strong solution, even if repeated at reasonable intervals may develop a beneficial effect on the inflamed skin in a shorter time and in a more energetic manner. The influence on the epidermis, that means cornification, according to Unna, being about equal for the strong and for the mild doses, the contracting power on the blood-vessels comes into play in a much more pronounced manner and penetrates deeper into the tissue from a strong solution, at the same time allowing the development of a more energetic antiparasitic action. The practical results which I have seen in the different stages and forms of dermatitis have fully borne out the correctness of these views. The method of application would usually be the following: After cleaning the affected portions, if necessary, particularly after the removal of all remnants of ointments,

¹ *Correspondenzblatt f. Schweizer Aerzte*, 1891.

etc., and drying them well, the solution of ichthyol or thiol is thinly spread over them by means of a small tuft of absorbent cotton wound around a wooden toothpick or other similar contrivance, and allowed to dry, a powder or a very thin layer of absorbent cotton being applied afterward if desirable. A fifty-per-cent. mixture is preferable to the pure drug because it is more liquid and more easily handled. With the corneous layer intact, the solution scarcely causes more than a slight transient burning, but no pain; where the deeper layers of the epidermis or the cutis are exposed more severe burning follows, usually, however, of very short duration. The patient is advised to leave the affected parts undisturbed for from twelve to twenty-four hours and afterward to rub in some mild preparation suitable to the conditions, usually without removing the remaining ichthyol. The effect on the redness and swelling is very conspicuous, while a diminution or entire disappearance of the sensory symptoms, itching and burning, is almost regularly experienced by the patient. Some mild treatment is then continued as long as further improvement is obtained; as soon as it ceases a strong solution is applied again. This plan of treatment, of course, is subject to modifications, according to the character and phase of the dermatitis.

The most virulent and aggravated type of dermatitis is represented by erysipelas. The excellent effects of ichthyol in this disease are so well and widely known that it is sufficient to simply mention the same, the more so as I have nothing new to add except that the strong aqueous solutions are preferable on all parts of the body to ointments except where the presence of longer hair makes the latter more handy. It seems that the powerful influence of ichthyol on erysipelas has generally been attributed to the antiparasitic qualities alone, and for that reason its employment heretofore has not been extended to other forms of acute dermatitis not due to parasites.

Dermatitis venenata ranks next to erysipelas in severity, the conditions of the skin often being found of such intensity that at first sight it may be very difficult to decide with which of the two diseases we have to do. The excellent results which I have seen in dermatitis venenata have mostly induced me to call your attention to this treatment. This seems the more justified as the more severe types of this disease, particularly poisoning from rhus, are much more common and better known on our continent than in European countries, and as other modes of treatment are not always satisfactory. Last summer we had an unusually large number of such cases in our service in the German Dispensary. Wherever it was possible the affected parts were immediately painted with fifty-per-cent. ichthyol

and in almost all cases the disease ceased to spread any further, swelling and redness were rapidly reduced, together with burning and itching.

For the sake of illustration I may be allowed to report more in detail a case treated during last August in private practice: The patient, a man about twenty-three years of age, who had had attacks of poison-ivy dermatitis for the last four years, returned home from Long Island three days after the present outbreak of dermatitis which had developed with much more severity than the former ones. The face was of a deep red color and enormously swollen, so that the features of the patient were hardly to be recognized. The affection extended to both ears, the forehead, and about the anterior half of the scalp and the larger part of the neck. Numerous small and large blisters and moist patches, devoid of the upper layers of the epidermis, partly covered with scales and thin crusts were distributed over the entire affected surface. Both hands and knees were also affected but in a minor degree. I applied immediately a fifty-per-cent. ichthyol solution over the diseased parts, then dusted them with the stearate of zinc and spread thin layers of absorbent cotton over the denuded, oozing portions. The slight burning experienced from the application of the ichthyol passed away after a while to give way to the almost absolute absence of disagreeable sensation, and the patient spent a comfortable night. Every two hours the face was moistened with pads of cotton soaked in a one-per-cent. solution of ichthyol. Except a few small spots on the extremities the disease did not extend. The strong applications were repeated once a day for five days after freeing the surface of the cotton and the detached epidermis and after cutting open with curved scissors the remaining blisters and bullæ. After the fifth day the ichthyol was applied only to the most severely affected portions around the eyes and ears and on the neck, while for the more improved parts a mild boric-acid ointment was used. On the eighth day the patient went to business with scarcely a mark on his face except a few slightly scaly patches which disappeared under the use of the boric-acid ointment.

I am unable to state whether ichthyol has any specific effect on the toxic principle of the rhus plants. According to the recent investigations of F. Pfaff, made in the pharmacological laboratory of Harvard University,¹ it seems that the toxic agent is not toxicodendric acid, as heretofore assumed, which he found identical with acetic acid, but toxicodendron oil, a non-volatile, intensely active and enormously sticky oil, which in the presence of alkalies is transformed

¹ *Journal of Experimental Medicine*, ii, 2.

into a non-toxic resinous substance. I have not been able to ascertain whether the reaction of ichthyol is alkaline; it certainly is not acid. I am inclined to believe that the good results were largely due to the fixation of the toxic substance by the drying of the ichthyol, which prevented further spreading of the oil and allowed of its quicker decomposition.

Dermatitis caloricæ, both as *d. ambustionis* and as *d. congelationis*, offers another fruitful field for the treatment. Unna has claimed already that in burns of the first degree the immediate application of ichthyol (strength not mentioned) removes in a very short time the pain and almost every visible sign. In more intense cases it prevents the formation of blisters and reduces the symptoms either entirely or to the condition of the first degree, ending in the detachment of a fine horny cuticle. He does not recommend its use in burns of the third degree. From a rather limited experience with burns I can confirm Unna's statements. Of dermatitis congelationis I have also seen but mild affections of the ears, nose, fingers, and toes; they were all quickly cured with the ichthyol treatment.

Here I mention under the common name of dermatitis traumatica acute inflammatory conditions often associated with pustulation, which, almost always the result of scratching, are found associated with scabies, trichophytosis, and other itchy troubles. The presence of pus is not a contraindication against the strong solutions of ichthyol, which usually have a rather quieting effect in such cases. Intertrigo, a dermatitis due to the rubbing of the skin against an opposite surface of the skin or against the clothes, according to Unna, is quickly checked in its course by a strong application of ichthyol.

In a number of cases of herpes zoster the local symptoms, hyperemia, swelling and burning, have rapidly been reduced by painting the blotches over with ichthyol; in the early stages it seems to prevent the full development of the lesions.

Tempted by the good results obtained in the different forms of dermatitis I soon tried the same strong solutions in cases of acute eczema and of acute exacerbations of chronic eczema. My experience has been eminently satisfactory, so that, wherever it is possible on account of the location and other external circumstances, I rarely omit to inaugurate treatment with a coat of ichthyol solution. It is often remarkable to observe the quick change of the acute condition into a milder and more subacute one. I again assert, that even on moist surfaces the pain is neither intense nor of long duration, and that I have never observed an exacerbation or other bad effects. I have not seen any difference in the results between the apparently

parasitic or seborrheic forms and the common eczema, which Unna formerly designated as nervous and tuberculous eczema.

In the following diseases I have not had any experience, or a very limited one, with the treatment, but I should certainly expect favorable action in erythema multiforme, dermatitis herpetiformis, and urticaria. Unna has reported a case of lichen urticatus in which he painted mornings and evenings the entire body of a child six years of age with a fifty-per-cent. aqueous solution of ichthyol. I should expect equally good results in variola, measles, and particularly in severe scarlatina, and feel the more inclined to recommend or to employ these applications, the less danger there is connected with them in the face of the absolutely non-poisonous character of the drug.

I shall but briefly consider the *chronic inflammatory conditions* of the skin in their relations to this treatment. Infiltrated patches of chronic eczema, of lichen complex circumscriptus chronicus (Vidal), and even certain forms of psoriasis offer a favorable field. Naturally the application of the strong solutions appears less paradox than in acute cases, because there is much less danger of a possible irritating effect. Indeed, the usual treatment is called a stimulating one, and it is well known that the artificial production of an acute stage of inflammation is often indicative to a more rapid reduction of the chronic infiltration. To produce a more rapid absorption I used to apply chrysarobin dissolved in chloroform, followed in some instances by a coat of collodium. But the objectionable qualities of that remedy made me look for some other less disagreeable one, which I found in ichthyol. Periodically applied to the surfaces, after cleaning them as far as possible of all greasy substances and scales, ichthyol, thiol, and tumenol show, indeed, a beneficial influence, but not always so decidedly as would be desirable. They are followed by the usual ointments or pastes of salicylic acid, resorcin, tar, white precipitate, etc. Patients have often spontaneously reported that the improvement in their condition seemed always to get a new impetus after these applications. The results, however, become much more pronounced if the applications are preceded by a cauterization or even a stronger irritation, which temporarily produces a more acute condition. My favorite remedy for this purpose is the liquor potassii, which was originally recommended by F. Hebra, and more recently again by Duhring, but to judge by the hand- and text-books is hardly in common use. From my own experience, however, it is not advisable to use it in the full strength of thirty per cent., but to begin with dilutions of the officinal liq. pot. according to the locality and to the condition of the skin, individuality playing an important part. The ap-

plication is made in the following manner: A bunch of absorbent cotton is dipped into the solution and thoroughly rubbed over the affected parts, which are then wiped off with water and dried. In this way the scales and the upper layers of the horny epidermis are rapidly removed from the diseased portions and their surface completely exposed, while the healthy skin suffers only a thinning of the horny layer. It is often surprising to notice the appearance of eczematous lesions on parts which before appeared perfectly normal. To this cleaned and partly denuded surface the strong solutions are now applied in the same manner as in acute conditions and so a much stronger effect is secured. Repeated within suitable intervals and followed by some more or less strong ointment in the intervals the chronic infiltrations can be reduced in much less time than otherwise.

Being fully aware of the responsibilities of recommending some particular method of treatment and of the disappointment which some of you are not unlikely to suffer if you try to follow my advice, I wish to repeat here the words with which Kromayer concludes the chapter on general therapeutics in his "*Allgemeine Dermatologie*." Referring to the numerous new drugs which are constantly brought into the market and recommended as highly effective against different diseases of the skin, he says:

"While we are occupied with these new drugs and try to define their indications, we naturally neglect in the same proportion the old well-tried remedies; we unlearn and forget their mode of application and their more subtle indications if ever we knew them, or as is frequently the case, we are prevented from ever becoming acquainted with them. Even with the comparatively small number of old, well-tried remedies, it is extremely difficult to control them in their effect on the various diseases in such a manner that we could say in the single case: this drug in such concentration and applied in such a manner will give the most sure and prompt results. Yet the more we employ the same remedy over and over again, the more we apprehend the real nature of the remedy itself and of the pathological process which is influenced by the same, and the more we understand that we are far from knowing it perfectly and thoroughly. Under our very hands, however, it becomes a more and more docile, suitable, and sure weapon in our combat against disease."

42 East Twenty-second street, New York.

Society Transactions.

BRITISH MEDICAL ASSOCIATION.

REPORT OF TRANSACTIONS IN THE DERMATOLOGICAL SECTION. MONTREAL, AUGUST 31ST TO SEPTEMBER 3D.

The Chairman of the Section, MR. MALCOLM MORRIS, F.R.C.S., Edinburgh, Surgeon to the St. Mary's Hospital of London, delivered an opening address upon

The Rise and Progress of Dermatology. — Beginning with the forerunners of Willan, dermatology was traced down through the Greeks, Arabians, and medieval writers. Although the victories in this branch have, perhaps, been less showy than those won in some other special departments it cannot be said to have lagged behind in the onward march of medicine.

Willan, to whom the Medical Society of London awarded a gold medal in 1790, may justly be called the creator of dermatology. The first treatise devoted professedly to the skin was published in Venice by Hieronymus Mercurialis in 1572. Turner's work, published in the early part of the eighteenth century, was almost wholly a compilation of what had gone before.

The birth of dermatology may be put down as 1808, when the first volume of Willan's "Treatise" appeared. The scope and classification of this work was reviewed by the speaker as well as the influence exerted by the classification of Von Plenck.

Willan's judicious selection and accurate definition of terms constitute this writer's chief title to be considered the founder of dermatology. It was his teaching that transformed a confused jumble of folk-lore into a science. It was fortunate for the English school that Willan left behind so competent a disciple as Thomas Bateman. His "Practical Synopsis of Cutaneous Diseases" did far more to make his learned preceptor's name and work known than the latter's incomplete treatise.

The influence upon the English school of Thompson, Parkes, Wilson, Hillier, and Tilbury Fox was dwelt upon, and a tribute paid to Mr. Jonathan Hutchinson as its present living leader.

After a consideration of the independent rise of the French and German schools, the American school was discussed in the following terms :

"The history of dermatology in America has been written by Professor J. C. White of Harvard, and by Professor Louis A. Duhring of Philadelphia, from whom all that can here be said on the subject is taken. For the first thirty years or more of the century little or no interest was taken in cutaneous affections in America. A story is told which, whether true or not, serves to illustrate the state of things in those days. A student, asking for information as to a disease of the skin from a physician, was met with the reply : 'Sir, I know nothing of the skin-diseases; you must go to a surgeon.' On his applying to the surgeon, the answer was: 'Sir, I must refer you to the physician.' In fact, as Duhring tells

us, a disposition existed to consign the whole of this branch of medicine to those outside the professional pale. No one seemed prepared to take up the matter. Still, even at that period, there was a demand for information on skin-diseases which booksellers thought it worth while to supply. Bateman's 'Synopsis' was republished at Philadelphia in 1818, a second edition being issued in 1824, and a translation of the work of Cazenave and Schedel appeared in the same city in 1829, a second edition being published in 1832. In 1845 appeared the first American work on dermatology. It was entitled 'A Synopsis of the Symptoms, Diagnosis, and Treatment of the more Common and Important Diseases of the Skin,' and its author was N. Worcester, Professor of Physical Diagnosis and General Pathology in the Medical School of Cleveland. The book is described by Duhring as being little more than a compilation from the works of the French and English dermatologists of the day.

"Meanwhile, other signs of a growing interest in the subject were not wanting. In 1836 an Infirmary for Diseases of the Skin was opened in New York, being the first institution of the kind established in the United States, and lectures on skin-diseases were delivered there, and afterward in some of the medical schools of New York between the years 1837 and 1854 by Dr. H. D. Bulkley, father of Dr. L. D. Bulkley, whose name is well-known to all dermatologists.

"At this time Paris was the center of the dermatological world, and American students accordingly went there for instruction in the subject. Hence for many years American dermatology was the direct offspring of the French school, the influence of which was only slightly tempered by reprints of the works of Wilson and other English writers. At a later period Americans flocked to Vienna, and on returning home spread the doctrines of Hebra among their countrymen. As early as 1859 Hebra's teaching was made known in America by Professor James C. White, who, two years later, gave the first course of lectures on diseases of the skin at Harvard. After the Civil War clinical lectureships on the subject were established in several important schools. In 1870 the foundation of the *American Journal of Syphilography and Dermatology* did something to promote the advancement of the knowledge of skin-diseases in America, and the establishment of the American Dermatological Association in 1877 gave a powerful impulse in the same direction, which was further aided by the creation of the *Archives of Dermatology*. Yet in 1871 Professor James C. White complained that as yet America had contributed little to dermatology, and that this branch of medicine had hardly then found a place among his countrymen as an acknowledged specialty. Now this reproach has been wiped away, and American dermatology, represented by Duhring, James C. White, and others, is recognized as being in the van of progress."

Dermatology at the present day may be said to be international. A fusion has been accomplished by the influence of translations,

multiplication of journals, and pilgrimages to dermatological shrines.

Progress in knowledge of pathological processes is chiefly the achievement of the German school and has greatly simplified matters. Much confusion has been done away with by distinguishing the primary and essential lesions from the secondary and accidental. Real progress is measured by increase of knowledge of causes of disease, and in this respect it may be said that as much has been accomplished in dermatology as in any other branch.

The etiology of a very considerable proportion of skin diseases is now accurately known, and still "the fact that only forty years ago a dermatologist of the first rank could in one sweeping anathema condemn root and branch the doctrine of parasitism in skin diseases is one of the most striking proofs of the youthfulness of scientific dermatology, and of the progress which it has made in its lusty childhood."

Thomson asserted in 1850 that though favus had been ascribed to a mycoderm there was no proof. He held that the pustules constituted the disease in ringworm and that the mycoderm merely finds its habitat in them.

Chausit, a pupil of Cazenave, argued as late as 1863 that there was no disease of essentially parasitic nature and hence should be no antiparasitic therapeutics. Cazenave never recanted his heresy, and Erasmus Wilson also died an unbeliever. Recent investigations suggest that the boundary line between ringworm and favus is by no means so definite as has hitherto been believed. Mycology is still a promising field for the young dermatologist.

The important influence of bacteriology in the advance was shown by the many affections already known to be due to specific micro-organisms. "In almost every case of skin disease the primary and essential process is at some period of its course complicated, and it may be overshadowed by secondary lesions. To bacteriology we owe the knowledge that these are due to the action of pyococci and streptococci, whose attacks the skin resists in health, but to which it falls an easy prey when diseased. The importance of this knowledge, both in relation to diagnosis and to treatment can hardly be overestimated."

Progress has been made in three ways: (1) We have got rid of some superstitions; (2) we know better where to direct our attack; and (3) we have more effective weapons.

Among the superstitions that hindered progress, one of the most pernicious was the notion that skin disease was a natural issue for the escape of peccant humors—a safety-valve for the constitution. The polypharmacy of the older school is almost a thing of the past; and we certainly cure more scientifically than did our forefathers; we can treat symptoms more effectively, and are milder in our methods. It is of no great practical import that we have no complete classification; but a real stumbling-block is the confusion of terminology. A nomenclature at once simple, precise, and yet descriptive and international would be a real help to progress.

The first paper read was one by DR. GEORGE T. JACKSON of New York, entitled

Report of a Case of Multiple Idiopathic Pigmented Sarcoma (Kaposi Type).—Colored drawings were presented of the case described which had existed for twenty-one years, with widely distributed lesions involving the legs, feet, etc., in a male subject of forty-seven years of age, born in Nova Scotia. A pathological report by DR. ELLIOT, also of New York, formed part of the paper. This showed the type of lesions to be those of pigmented spindle-celled angiosarcoma.

In the discussion DR. HYDE (Chicago) spoke of cases which had derived benefit from arsenic in its fullest dose. He thought that because of this good effect of arsenic, if for no other reason, these cases should be separated from other forms of sarcoma.

DR. GALLOWAY (London) said the connective tissue-cells were not the same as those seen in sarcoma. They were degenerate cells and resembled those produced by chronic irritation of connective tissue. He would also take these cases out of the category of sarcoma. He referred to an instance in the practice of Dr. Stephen Mackenzie which he had been able to observe and study for about ten years.

DR. CORLETT referred to three cases in which the tumors tended to increase.

The next paper on the

Non-Surgical Treatment of Boils, Carbuncles, and Felons was presented by DR. L. D. BULKLEY (New York). The reader advocated the avoidance of the knife as well as poultices. He would treat the underlying general condition which was in most instances in some way deranged. Subjects of these conditions are never in good health, and overwork, worry, etc., may usually be found. Treatment consisted in a mercurial purge, followed by Startin's mixture and the sulphite of calcium. It is most important that a good article of the latter drug be obtained, that the pills be made freshly, gelatin-coated, and given in a dose of one-quarter grain every two hours. Externally, he employed carbolic acid, ergot, zinc, and starch in form of ointment. Felons are to be treated by internal and general means, and the application of Hebra's diachylon ointment, which prevents the necessity of resorting to the knife, resolution taking place, or the pus reaching the surface.

The Chairman, MR. MORRIS, took issue with the reader, and disagreed with nine-tenths of all he had said. He avoided drugs unless there was a clear indication for their use. In carbuncle he favored scraping out under anesthesia and thus securing in a few hours the rest and benefit which many weeks of applications would require. He was surprised that so much of medieval medicine had survived. The school which Dr. Bulkley represented was dying—but dying hard.

The next paper was read by DR. W. F. CORLETT of Cleveland on

The Value of General Therapeutic Measures in the Treatment of Diseases of the Skin, in which the benefit to be derived

from internal medication in many forms of eruption was pointed out and the importance of dietetic and hygienic measures advocated. The Chairman, DR. MORRIS, said the question was this, whether the affection was local or constitutional in origin. He entered an urgent protest against indiscriminate medication and the precautions of diet which held an exaggerated position in the eyes of many. The drug habit is worse than the spirit habit. Instructions as to general health measures and hygiene should be left to the school-teacher.

DR. GEORGE H. FOX (New York) thought that the physician's duties extended far beyond the writing of prescriptions. He should go into the daily life of the individual and seek to regulate all habits. He believed that many skin cases would do better in the hands of an athletic trainer ignorant of all pertaining to medicine than in the care of a physician who relied solely upon drugs.

The Dermatological joined with the Section on Pharmacology and Therapeutics in a discussion on

The Treatment of Syphilis, which was opened by DR. WHITLA of Belfast, who considered the question under the following heads: (a) How mercury and the iodids are supposed to act in syphilis? (b) When should mercurial treatment be started, especially should it be given in the primary stage? (c) The various methods for its routine administration, dosage, etc., and the length of time necessary for mercurial treatment; (d) The treatment of tertiary and congenital syphilis.

While iodids need not be given in the secondary stage, or at least not for the first six months, a marked febrile temperature is an indication for their use in the early stages. The sodium is preferred to the potassium salt. When smaller doses do not do good they should be increased.

Mercury has been proven to have a specific curative effect. It is the vital antidote to the poison. So long as the virus remains in the organism mercury will expend its force upon it without injury to the patient. This gives a working hypothesis as regards dosage. The continuous and interrupted methods cannot be rigidly separated, though personally he favored the continuous. He prescribed small doses as early as possible in the affection, as soon as the diagnosis is made. Variations in the patient's weight were considered important as a guide to the dosage and the weight-chart should form part of each history. Inunction was the most generally useful method of administration despite its disadvantages. He usually began treatment by a course of Plummer's pills, which also contained guaiacum. For inunction the Ung. Hydarg. of the German Pharmacopœia was far preferable to the English. Taylor's inunction method was well spoken of as well as the theory upon which it was based.

For the continuous method, he gave mercury with chalk in grain doses six or seven times daily, and thought it better to choose one preparation and stick to it throughout. In the tertiary stage, he was in the habit of pushing iodid, perhaps combined with ammonia, until the symptoms abated.

DR. J. NEVINS HYDE said we should have no routine plan in the

treatment of syphilis. There were two extremes; the mild cases which recovered without treatment and the severe which are speedily fatal in spite of any treatment. The best results are in those cases in which no iodid has been used. We must remove the possibilities of the grave consequences of the disease. The patient's constitution is the most important point in this connection.

MR. MALCOLM MORRIS agreed fully with all that Dr. Whitla had said. He would divide syphilis into two great groups: Syphilis in those who take alcohol and those who do not. Mercury acts directly upon the poison itself and by increasing metabolism, a double action. It should be commenced at once. By delay the patient loses valuable time. As to method, he prefers that by inunction, and had given up all greasy preparations for a soapy one made with molin. There is no absorption of fat. He believed that for some unknown reason extragenital syphilis was more severe than that contracted in the usual way. As vehicle for the iodids he believes in sarsaparilla as the best and combines the iodid with a little ammonia. It can also be given well in food, as hot soup, so as not to irritate the stomach.

DR. HERVIEUX (Montreal) said such discussion of the question would continue so long as the constitution of the disease is not better known—once the cause is found the proper remedy will follow.

DR. C. W. ALLEN (New York) took issue with the last speaker, stating his belief that if we were to-day positive that any bacillus already discovered were the true cause or a new one should be found, we would go on for a long time discussing and treating in the same manner.

We have always to remember that it is an individual with syphilis whom we are treating, and not simply a disease to be combatted in a routine way. While inunction was the initial treatment of preference for the majority of instances, the injection of soluble salts of mercury, as the bichlorid, combined with chlorid of sodium, gave excellent results, and many of his patients, both private and public, preferred it for reasons of cleanliness, secrecy, etc.

He was glad to hear Dr. Morris advocate immediate treatment. In taking the ground himself that treatment should be begun as soon as the chancre was diagnosticated, he was not upheld by text-book writers and teachers in the United States. The objection raised by Dr. Whitla and others in opposition, that the physician is left in doubt, is not well founded. If the patient is carefully observed, all doubt will be dispelled before the end of a year by confirmatory signs—though they may be few and slight. Personally, he had not found the average of extragenital syphilis more severe than that of genital origin, though he was prepared to accept the statements of others that such was the case.

He thought the relative abundance of lymph-nodes in certain situations might be a possible explanation, offering a barrier to the rapid dissemination of the poison.

DR. BULKLEY (New York) believed extragenital syphilis more severe than genital, because so large a proportion of instances were overlooked and hence neglected, the diagnosis being made late. His

theory as to remedies was that iodids remove the lesions while mercury attacks the vital element upon which the lesion depends for its existence. This is true even of late syphilis, and for this reason he combines a small dose of mercury with the iodids in tertiary syphilis. A smaller dose of iodid will answer in a given case, if mercury be thus combined with it.

DR. LEECH (Manchester) who had occupied the chair, said he was pleased that no drugs outside of mercury and the iodids had been mentioned for the cure of syphilis. Sarsaparilla which is often used is not the inert drug it is usually taught to be. He thought we would know more about treatment when the cause is known. He was glad to hear Dr. Hyde protest against the use of the term tonic treatment by mercury, as employed by Dr. Keyes and others. Mercury is not tonic. The only contraindication to its use of which he knew was perforation of the palate.

DR. WHITLA in closing said he would confess that he often eases off the continuous treatment to permit evidences of the disease to appear and convince him that there has been no mistake in diagnosis when treatment has been begun in the chancre stage.

He referred to the brilliant results in hydrophobia by the Pasteur treatment as a disease in which the microbe had never been seen, though known to exist.

He could not accept Dr. Allen's hypothesis in accounting for the severity of some extragenital syphilis since the experiments of Taylor show that the poison enters and disseminates through the blood at once. He had never seen harm from mercury.

NEW YORK DERMATOLOGICAL SOCIETY.

TWO HUNDRED AND SIXTY-FIRST REGULAR MEETING, HELD ON
TUESDAY EVENING, APRIL 27, 1897.

DR. J. A. FORDYCE, *President, in the Chair.*

A Case of Nævus Vascularis.—Presented by DR. E. B. BRONSON.

The patient was a young woman, twenty-two years old, with a vascular nævus, that extended from the bridge of the nose upward to the margin of the scalp, and was about an inch broad at its widest part. Dr. Bronson said that when he first saw the case, several months ago, the lesion had an elevation of about one-quarter of an inch and a deep purplish hue. Under electrolysis the elevation had almost entirely disappeared and the color was considerably lighter. He asked the opinion of the members as to whether a continuance of the treatment would result in much further improvement.

DR. G. T. JACKSON thought the result thus far was certainly satisfactory and advised that the electrolytic treatment be continued. He thought it was possible to destroy entirely the red color of the lesion, but the treatment should be pursued cautiously, lest the skin became too white; still, that would be preferable to its pres-

ent red color. He advised multiple punctures with the electrolytic needle.

DR. S. SHERWELL said that some years ago he was quite enthusiastic in regard to the treatment of these lesions with carbolic or chromic acid pricked into the skin with grooved needles, for which he devised an instrument. He still occasionally employed this method in cases where the *nævi* were of small size, and perhaps it might prove beneficial in this case, but he thought a better method would be to treat the case surgically, excising the lesion and then bringing the cut edges together or employing skin grafts, if necessary. The treatment by means of multiple punctures with chromic or carbolic acid he had found most serviceable in the class of *nævi* where the capillary and venous circulation seemed to be implicated rather than those of arterial origin. Multiple punctures were made, and then, after the bleeding had ceased, contractile collodion was applied, which acted as a compress. The result was good in some instances, while in others it proved disappointing. The erectile, vascular type of *nævus* he has usually found much more amenable to treatment than the purely cutaneous type, namely, that in which the capillary dilatation is confined to the *corium*.

DR. H. G. PIFFARD said that while he had never operated on a *nævus* as extensive as the one shown by Dr. Bronson, he had treated a number of smaller ones by means of scarification with the actual cautery. Depending on the size of the lesion, from four to six scarifications are made at a sitting, making them as nearly as is practicable in one direction; after two or three weeks the lesions are scarified in a similar manner, but in the opposite direction, and at a third sitting the scarifications are carried across diagonally. The method described seems to give the best results in superficial vascular *nævi*. In reference to the suggestion made by Dr. Sherwell, namely, that the lesions be excised and grafts inserted, after Thiersch's method, the speaker expressed the opinion that it would be a difficult matter to obtain forehead skin for the purpose, and skin taken from some other locality would hardly answer.

DR. LUSTGARTEN expressed the opinion that electrolysis is usually disappointing in these cases in the long run, although in the beginning the result may appear very gratifying. The treatment is very prolonged, and while you may succeed in flattening the lesion, the skin usually remains red. He thought the actual cautery would be preferable, although it should be used cautiously so that too much destruction of tissue does not take place.

DR. BRONSON said that while there had been a marked change both in the elevation and color of the lesion, since the patient had been under his care, he was doubtful as to the ultimate result. He was inclined to think that something more could be done, however, by continuing the electrolytic treatment. The case had arrived at that stage where he could work with more certainty. In the early stage he simply plunged the needle into the elevated purplish masses, which had now disappeared, so that the vessels could be seen and the needle inserted directly into their caliber. The speaker referred to

the danger of doing too much, with the result of producing an excess of scar tissue.

DR. JACKSON said he did not think the electrolytic treatment of nævi disappointing if it is done carefully. There is no doubt about the possibility of destroying these lesions entirely if a sufficiently coarse needle be employed; if the punctures are not made too close together we get a smooth skin which is pinkish in color. He employs a current of from two and a half to five milliamperes.

DR. ALLEN referred to a number of cases of nævi which he had treated by means of electrolysis with very satisfactory results. When the areas involved are of large size the treatment does not do so well.

A Case of Dermatitis Due to X-rays.—Presented by DR. E. B. BRONSON.

The patient was a lady, thirty-three years of age. In order to learn the condition of an injured hip-joint, a series of attempts to photograph the joint by the X-rays was made in December last. The first exposure was on December 14, 1896, and was continued for one hour and twenty minutes. The tube was fixed opposite the abdomen, at a distance of about six inches according to the patient's statement, though the operator alleged that it was fifteen. The rays fell over the area between the navel and the pubes. The skin was always covered by the chemise. Four subsequent attempts were made at intervals of a few days, each of about one-hour's duration, but all were unsuccessful. During and immediately following the exposures no effects were noticed; there was no feeling of heat; no eruption. In the early part of the next month the patient noticed a rash of a papular character on the abdomen, extending from an inch or two below the navel down to and into the hair of the pubes. Later it became confluent in the middle and of a deep, purplish-red color. The attending physician pronounced it erysipelas. The edges were not sharply defined; there was no vesiculation nor desquamation. At the suggestion of a friend the patient applied a hot poultice of cranberries, which was followed by exfoliation over the central portion of the patch, leaving a moist, eroded surface. This surface was at first about five inches long by two or three inches wide; it was depressed and soon became covered with a grayish membrane. The lesion was treated with lead-and-opium wash and various other things, including later the actual cautery over one portion. It was exceedingly sensitive. It healed at first to some extent but lately there has been no progress. Another effect of the rays was complete loss of hair over the pubes but the hair had grown again.

When first seen by Dr. Bronson some three months after the trouble began there was an exulcerated surface with sharply-cut edges, about three inches long by one-quarter to three-quarters wide. It occupied the middle of the abdomen, the long diameter extending transversely. The raw surface was grayish in color, studded with red points, resembling a furred tongue with red papillæ showing through. The surface was moist without discharge. Here and there at the borders and in one or two spots outside were raised, len-

ticular, deep red papules, and where these occurred at the edges of the sore, the sensitiveness was especially marked. An areola surrounded the excoriation, and here and there are detached cloud-like areas of red. Beyond this was a glazed-appearing, atrophic zone, which was irregular in boundary. The pain that attends the affection is of a peculiar nervous character, which the patient cannot easily describe. Sometimes it is of an intense burning character, and often seems to extend deep in and courses down the limbs and over the entire abdomen.

The methods of treatment useful for ordinary burns have had no good effect. Lassar's paste, with or without ichtlyol, carron oil, weak picric-acid ointment, cocain ointment, nosophen, ointments containing morphin and bicarbonate of soda have all been tried, and all seem to aggravate the discomfort. They can be borne only for about an hour, when the pain begins to increase until the application is removed. Slight temporary relief was given by applications of warm water. On February 24th pure carbolic acid was applied to the surface with the object of annulling the hyperesthesia. For a half minute or so the pain was excessive, and when this subsided the sensitiveness and pains had disappeared leaving only a slight feeling of warmth. About four hours later the pain returned, however, and grew worse and worse until the patient was almost distracted.

DR. ELLIOT referred to two cases of X-ray dermatitis which he had mentioned at a previous meeting as occurring in a couple of boys who had been used as subjects for the demonstration of the rays. Large ulcerations developed on the sternum which persisted for a long time.

DR. ALLEN mentioned a case which occurred in the West. The patient was a man who had been shot, and after he had been exposed to the rays a number of times developed a sloughing ulcer of the abdomen which proved very obstinate to treatment, not showing any signs of healing for a long time.

DR. P. A. MORROW said that in a number of respects these lesions are peculiar. Their tardy development, their chronicity, and their extraordinary resistance to treatment are interesting features. The necrosis of the tissues is probably the result of the rays on the nerve-elements.

DR. JACKSON said this was the first case of the kind that had come under his observation. He advised treating the lesion surgically, cutting it out with quite a wide margin of sound skin about it.

DR. C. W. CUTLER also thought the quickest way to effect a cure would be to perform a plastic operation, removing the apparently diseased tissue and bringing the edges of the wound together.

DR. LUSTGARTEN said this subject is an entirely new one, and the nature of the rays coming from the Crooke's tubes are not yet understood. The late development and long duration of these lesions are difficult to understand. In the case shown by Dr. Bronson the lesion reminded him of the atonic, gangrenous ulcers occasionally seen in hysterical subjects, which are usually brought out by

some form of trauma. It would be well, he thought, to examine the patient for hysterical stigmata.

DR. H. G. PIFFARD said that in connection with the history of these cases, it would be interesting to know whether the induction-coil or the static machine was used. It has been said that the latter is less apt to give rise to these tissue changes than the former. Several theories have been advanced as to what the X-rays are, and how they are brought about. At one time they were regarded as transmitted vibrations in some substance more tenuous than that which we have heretofore called ether. Again, it was supposed that they were transverse vibrations in ether, but of a shorter wave-length than any that have been recognized as coming from sunlight or any other illuminating source. Third, Tesla has recently stated that they are not transverse vibrations, but a rapid bombardment of a material substance of some sort, probably of metallic particles from the electrode, and he also states that there is a difference in the effect produced by an aluminum and a platinum electrode. As regards the treatment of these lesions, the speaker said he would be inclined to try a very weak electrical current.

DR. BRONSON, in closing the discussion, said he could not entertain the suggestion made by Dr. Lustgarten that there might be a hysterical element in this case, as it was so precisely analogous to other cases of X-ray dermatitis that have been reported. As to the cause of these lesions, Dr. Bronson said that was still an open question. The ozone theory, he thought, was controverted by the fact that it is usually not only the surface that is affected by the contact of the X-rays, but the deeper tissues as well. In one case on record the skin, nerves, and bones of the hand were markedly involved; there were decided evidences of an osteitis. Implication of the nerves was shown by the fact that for several months the hand was paralyzed. There was also excruciating pain, which extended into the hand and up the arm to the elbow. In some of these cases the reaction occurs directly after an exposure, while in other cases the inflammation may not set in until several weeks after the exposure; it is apt to increase in intensity for a considerable time after its first appearance. Whether it is due to a bombardment of metallic particles, as Tesla has suggested, it is difficult to say. In the case reported by Dr. Gilchrist (*Bul. Johns Hopkins Hos.*, February, 1897) a platinum electrode was used, and Gilchrist examined the tissues for platinum, but no evidence of that metal could be found in the excised portions. Dr. Bronson said he would be doubtful about the effect of an operation to remove the diseased parts with a knife. In a very similar case at the Post-Graduate Hospital, Dr. Powell had excised the lesion, but the ultimate result had not yet been announced.

DR. MORROW said in the case reported by Dr. Gilchrist, which was referred to by Dr. Bronson, the trophic disturbances were very similar to those accompanying the neurites of leprosy.

A Case of Morphœa.—Presented by DR. BRONSON.

Male; aged thirty-one years; an accountant. The patient first

came under Dr. Bronson's observation on February 16, 1896. He had syphilis when he was twenty-one years of age, the symptoms of which existed off and on for two years. He then remained well with the exception of occasional lesions in the mouth until a year or so ago, when he began to complain of heat and sweating of the scalp after meals and after slight exertion. About six months ago an eruption of a superficial character appeared on top of the head. This soon disappeared. Last November he began to notice red streaks on the forehead and a month later a sore appeared near the junction of the frontal with the parietal bones. The sore was extremely sensitive and painful. It gradually extended until it was two inches long by half an inch wide. In January another similar area started a little to the left of the center of the vertex; it was circular and about the size of a 10-cent piece. When the patient was first seen by Dr. Bronson, two broad bands of reddish color, but evidently somewhat atrophic, were noticed on the forehead. One extended from the inner edge of the eyebrow directly upward for about three inches, wholly on the left side. It was about an inch wide. The other began near the outer end of the left eyebrow and extended distinctly about as far up as the inner streak, but at times a band of redness could be traced as far as the frontoparietal junction, or where ulceration began. The streaks, though usually appearing red, showed slight depressions with white atrophic spaces scattered over them. A network of fine vessels shows distinctly over the patches and it is to this that the redness is chiefly due. There seems to be no loss of sensation in the affected areas. In a line with the outer streak, beginning at about the point where the axis of the two streaks would meet, there is an ulcer three inches long by one-half inch wide. Its base is smooth, red, and moist, but without discharge. The edges are thin, not undermined, and not infiltrated, and slightly irregular in outline. A moderate areola surrounds them. At the vertex is another ulcer of similar character but of a more dusky color, bleeding more easily when disturbed, and almost perfectly round in shape. There is slight swelling of the region about. At present the anterior ulcer has healed (after four-months' duration) leaving a depressed cicatrix. The posterior one is still open.

DR. ELLIOT said that while he did not care to venture a positive diagnosis, the case, to his mind, suggested lupus erythematosus. He had observed atrophic lesions appearing along the course of the supra-orbital nerve and in other parts of the body in cases of chronic neuralgia, and in those instances the lesions were not scaly and there were no inflammatory signs.

DR. MORROW said he had not been impressed with the similarity of the lesions in this case to those which we are accustomed to recognize as morphœa. The whiteness and thickening of morphœa lesions, as well as the violet or erythematous border that is usually seen about such patches, were absent. He was inclined to regard the lesions as the result of some affection of the nerves, and men-

tioned the fact that he had observed similar atrophic scars as the result of zoster.

DR. A. R. ROBINSON said he did not regard the case as one of morphœa, judging by what he had seen and read of that affection. He thought the lesions in this case were the result of some nerve injury. They were similar in appearance to those observed by him several years ago in a patient who had had cerebral hemorrhage, followed by several attacks of very similar lesions, limited to one side of the face.

DR. BRONSON, in closing the discussion, said that his views regarding the definition of morphœa, had been modified by his visit to the International Dermatological Congress in London last year. The English, who have written a great deal about this affection, apparently regard almost every circumscribed atrophy of the skin as morphœa. A number of such cases were presented at the Congress. In some the atrophy was preceded by a lardaceous deposit, some showed the violet border, and in others the lesions followed the course of a particular nerve. Two patients were shown with what was called morphœa, in which there were atrophic areas occupying almost precisely the same places as those affected in his own case. Only the atrophy was more marked. In the case under discussion the small atrophic spots are very distinct. In general the redness predominates, and this color was to be explained in the same way as is the lilac border of ordinary morphœa; that is, the opaque parts of the skin having become atrophied, permit the small blood-vessels to show through the skin more readily and so become visible to the eye. There was evidently a nerve disease of some sort. At the beginning there was decided sensory disturbance. The sensation was difficult to describe; it was not a lancinating or smarting pain, but a feeling of tension or discomfort in the affected region.

DR. ELLIOT inquired why the case might not be one of lupus erythematosus?

DR. BRONSON said there had never been either inflammation or desquamation in the atrophic areas and the two ulcers were totally unlike anything in lupus erythematosus.

A Case for Diagnosis.—Presented by DR. ELLIOT.

The patient was a man forty years old, who, about eighteen months ago, began to suffer from an eruption on the palms of the hands; soon afterward it affected the soles of the feet and the scalp, and during the past six or eight months it has become more or less generalized. When the man came under Dr. Elliot's observation, about three weeks ago, the body was covered with an eruption which resembled in some particulars pityriasis rubra pilaris, in others dermatitis herpetiformis, in others a generalized eczema and also a chronic urticaria.

DR. MORROW thought the case was one of chronic eczema.

DR. BRONSON thought the case was essentially one of pruritus, with secondary eczema, and was doubtless due to some central or systemic disturbance. Dr. Jackson said he agreed with Dr. Bronson. Dr. Allen said he did not care to venture a diagnosis. He did

not, however, regard the case as one simply of eczema. Dr. Sherwell thought the case was one of acne and eczema in a debilitated and neglected individual.

DR. ROBINSON said that while he agreed essentially with Dr. Bronson, he did not consider the case one of pruritus primarily. Probably the direct exciting cause could be traced to some fault of the internal secretions. He failed to see any resemblance to pityriasis rubra pilaris, which Dr. Elliot had mentioned. The back of the hands showed a catarrhal dermatitis, and the small papules could be explained as a part of that process.

DR. PIFFARD regarded the eruption as a polymorphous condition due to some internal disease.

DR. KLOTZ thought that in some respects the case resembled a pityriasis rubra. The lesions on the face certainly did not resemble any form of eczema with which he was acquainted. He called attention to the extraordinarily dry xerodermic condition of the skin of the patient even in apparently healthy parts.

DR. ELLIOT said he had presented the case for diagnosis, and simply mentioned pityriasis rubra pilaris as one of the possibilities. He agreed with those who had expressed the opinion that an internal disease was the exciting cause of the cutaneous manifestations in this case, but the same is true of many other skin affections, and that explanation does not help us in reaching a diagnosis.

DR. BRONSON showed his new curette and follicle evacuator for the treatment of acne, and gave a demonstration to show how rapidly it accomplishes its work. (Described in *N. Y. Med. Journ.*, March, 1896.)

Selections.

SYPHILIS.

Chancre. BOYDAN (*Journ. des Mal. Cut.*, May, 1897) reports a case of double chancre of the labia in a child of seven years, acquired in an attempt at rape. In addition to mercurial treatment, the author excised one of the sores, including several cm. of healthy skin. The other cicatrized readily. In spite of medication, the chancre reappeared at the point of excision, larger than the primary. The child finally recovered entirely. . . . SENDZIAK (*Przegląd Chir.*, 1896) and WROBLEWSKI (*Przegląd Chir.*, 1897) give the histories of two cases of syphilis of the tonsil. The first found on examination a painful swelling of the right tonsil, cervical glandular enlargement, the tonsil covered by a white, thick membrane. The lingual tonsil was hypertrophied. No history was obtainable and a diagnosis was made only by exclusion. All symptoms disappeared after eight injections of mercury. The second case occurred in a woman, the infection carried by table utensils. The chancre was not amenable to treatment in the beginning but disappeared after six months. A gummatous recurrence occurred several years later. . . . Accord-

ing to the researches of EHLMANN (*Bull. Méd.*, 1897, p. 269), in the primary lesion, the induration follows the trend of the connective-tissue bundles and generally centers not in a blood-vessel but in a lymphatic. The virus enters an open point in the epidermis and gains the lymphatic system and nodes by the lymph-vessels. In secondary accidents, the poison has penetrated the blood-channels and they form the center of the lesions. A previous pathological state of the arteries will determine the form and grouping of an eruption. . . . AUDRY (*Journ. des Mal. Cut.*, February, 1897, p. 89) reports a case in which two chancres occurred separately and successively on the same subject. Between the 10th and 15th of December a chancre appeared on the prepuce and healed in ten days. On January 5th a sore appeared on the lip with the characters of a primary lesion. In this state, Audry saw the man on the 28th of January. He had continued connection with the same woman. The appearance of the second chancre showed that the man, although infected, had not been immunized at that time. . . . REY (*idem*) found thirteen simple chancres on the same subject. They were developed on ecthymatous lesions of scabies scattered over the thighs, abdomen, and penis, the virus being carried by the fingers in scratching. An inoculation on the chest gave positive results. . . . MAZET (*Journ. des Mal. Cut.*, January, 1897, p. 1) contributes a long paper on chancre of the conjunctiva. He reports a case in which the diagnosis was confirmed by later development of eruption and adenopathy. He says contagion is direct, indirect, or mediate, by kissing, washing the eyes with saliva, by the finger from the genitals, etc. It is generally single, occupies any region and presents the same characters as elsewhere, usually erosive or ulcerative. The preauricular ganglion is usually first involved. Treatment should be unirritating, by warm antiseptic washing followed by ointment of iodoform, eucrophen, or yellow oxid. . . . AUDRY (*idem*, p. 17) thinks the clinical importance of mixed chancre is not sufficiently recognized. Three of ninety cases were of this variety in his experience. Krefling has made ten complete observations in which Ducrey's bacillus was found in inoculations and specific accidents appeared later, and adds that he has met with so many mixed chancres in Christiania that it is perhaps due to the enormous prevalence there of chancroid.

Syphilis of the Internal Organs. BOURDIEU (*Annals de Derm. et de Syph.*, 1897, pp. 131-140, *Revue des Thèses*).

Bourdieu's contribution to *pulmonary syphilis* related to a man in life showing asthmatic, bronchitic, and bronchiectatic symptoms. At autopsy there was found a thickening of the connective-tissue skeleton of the lung everywhere, in addition to a generalized sclerogummatous change in all the tubes, with dilatation, to which the fibrosis was secondary. Diagnosis in such a case is made by the presence of other accidents, and the therapeutic test. The symptomatology is by no means characteristic. . . . Champenier sums up his investigations on *neuritis* as follows: "It appears during the first six months of infection. The patients complain of pain and

formication, which may be intense and persistent, with paroxysmal crises. There are motor disturbances as well, loss of power and atrophy, and diminution of electrical contractility. The cause is a peripheral, not a central lesion. In the absence of other causes, an osseous disease, exostosis, periostitis, may involve the nerve. Neuritis may be considered as an indication of malignant, precocious syphilis. . . . Bardury, writing on the *cerebrobulbar phenomena* in association with medullary symptoms of syphilis, says that they may precede or follow spinal accidents; more often the former happens. The disturbances most frequently seen are those of the eye, paralysis, diplopia, hemianopsia, diminution of visual acuity. The third nerves are oftenest attacked and the appearance of ocular paralysis is presumptive evidence of syphilis in a myelitis. Cerebral syphilis in congestive form comes next in importance; vertigo, fainting, transitory loss of speech and intelligence, possibly fleeting paralysis, epilepsy, aphasia, neuralgia, sensory disturbances. Without being able to give figures, Bardury believes that the phenomena occur in more than half the cases of spinal syphilis. . . . Schwab maintains that the prime cause of premature delivery in syphilis is disease of the *placenta*. All authors agree that it is pale, hypertrophied, and edematous. Placental lesions accompany hereditary, fetal or congenital disease, except in a few postconceptional instances. The microscopic change is a true cirrhosis of embryonal origin, attacking fetal and maternal elements. The first lesion is an endoperiarteritis and an endoperiphlebitis. The vascular disease is constant and results in perivascular infiltration and vessel obliteration. The stroma of the villi is altered and their epithelium proliferated or destroyed. Gumma is seldom seen. The changes are usually general, but may be localized with greater or less intensity in one part or another. . . . *Tertiary epididymitis*. Hector (*Annals de Derm. et de Syph.*, 1897, p. 221) has succeeded in gathering only 9 cases. It appears 2 to 20 years after infection, and in individuals in full sexual activity. Traumatism, gonorrhea, or previous inflammation determine its appearance. To be called tertiary, an epididymitis must exhibit (1) coexistence with other tertiary accidents, (2) rapid regression under iodid. One organ is attacked usually in its entirety. It is moderately hard and painful, and non-adherent to the testicle. The duration may be long and the termination be in sclerosis. Rochon (*Méd. Moderne*, 1896, p. 233) reports two cases to show the virulence of *spermatic fluid* in syphilis. The first was a chancre of the subumbilical region in a woman whose husband was in the habit of ejaculating extragenitally. The second occurred in a young woman whose lover transmitted syphilis to her, although he had no urethral lesion. . . . Stanziale (*Giorn. delle Mal. Ven. e delle Pelle*, 1896, p. 165) describes two cases of gumma of the *spleen*. In one, the disease consisted in a solitary nodule; in the other, they were numerous, small, isolated and irregularly disseminated through the parenchyma. Some showed central caseation. The vessel walls had undergone amyloid degeneration in other parts of the organ than the gummata. The arteries of the splenic

corpuscles showed a fibrous adventitia, a sign which may differentiate syphilitic from other splenopathies. . . . Rona (*Archiv f. Derm. u. Syph.*, 1897, p. 61) remarks that *bone fracture* due to syphilis is of rare occurrence and describes two cases in which the cause was gummatous osteomyelitis. The first had a benign attack at first, and was scarcely treated at all. Later he developed a frontal periostitis and thickening of the clavicles, cured by inunction. Shortly after, fracture of the left bone followed an abrupt movement. Complete union resulted. The second showed cutaneous lesions, osteoperiostitis and myelitis, fracture of the humerus, acromion, and both bones of the forearm, and gummatous arthritis. Spontaneous amputation ensued. A third case is given in which the left leg was amputated spontaneously in hereditary disease. The stump healed without treatment. . . . Mosca (*Giorn. delle Mal. Ven.*, etc., 1896, p. 173) gives the history of a similar condition, the fracture occurring at the juncture of the upper and middle thirds of the sternum. Complete repair followed treatment.

Hereditary Syphilis. R. MILLON (*Revue Men. des Mal. de l'Enfance*, 1896, p. 183).

The patient was a lad of fifteen. He had at the age of five grave ocular troubles; since the age of six, lesions of the knee and cutaneous gummata. At present, he has frontal exostoses, Hutchinson's deformation of the incisors, superficial ulceration of the legs, enormous knees, due to tumefaction of the lower extremity of the femur and distension of the synovial sac, considerable atrophy of leg and thigh muscles, and hypertrophied liver. Amelioration was secured by appropriate treatment but he died of cardiac lesions. . . . In a discussion on the persistent signs of hereditary syphilis during the Congress of German Physicians (*Annals de Derm. et de Syph.*, 1897, p. 113) Caspary called attention to the linear cicatrices combined with Hutchinson teeth as pathognomonic and stated his belief founded on histological researches, that the cell masses in the scars are scarcely admissible as syphilitic after a long lapse of years, but Galewsky and Riehl, quoting Neumann's opinion, pointed out the frequency of recurrence in these scars, especially in the pharynx and perineum. Jadassohn insisted that the hypothesis of cell residues is not necessary to explain relapses, for scars are easily influenced by irritations. . . . Paraphrasing Fournier's recently published lessons, FORTIN (*idem*, p. 137) denies that Hutchinson teeth belong only to hereditary syphilis. They are only indicative of malnutrition or arrest of development and are met with in infantile convulsions, scrofula, chronic enteritis, etc. Their presence carries only a presumption of the disease. . . . BOGDAN (*Journ. des Mal. Cut. et Syph.*, 1897, p. 200) describes a monstrous case of the disease. The woman, aged twenty-two, appeared only ten or twelve. Her body was very small, thin, rachitic, and deformed. She could not remain seated because of the deviation of the body over the pelvic basin and could not stand because the thighs would not support the body. The eyes, nose, and

mouth had disappeared in a huge cicatrix. The cachexia was naturally profound and she would lie, without moving, on her back for days. She could not speak, and, after some months of forced feeding and treatment, died. Gummata were found in the internal organs. . . . LE PILEUR (*idem*, p. 227) reports a case of acquired syphilis in a subject considered already syphilitic by heredity. The child was born of parents undoubtedly syphilitic and exhibited signs of degeneration, hebetude, malformed teeth (not Hutchinson), small cranium, rachitis, and mental crises, resembling epilepsy. Nineteen years later, some of these stigmata remained and the patient exhibited, beside, a chancre of the penis, which was followed by the usual accidents.

Technic of Mercurial Injections. D'AULNAY AND EUDLITZ
(*Journal des Mal. Cut. et Syph.*, No. 7, 1897).

This method of administration is one "of special indications." The hypodermic injections have their advantages and drawbacks. The first are practical, such as cleanliness, exact dosage, and certainty of application; social, secret treatment in families, forced medication of prostitutes and troops; medical, no untoward accidents to stomach or skin, better absorption, rapid treatment, surer action; physiological, the immediate introduction of the medicament into the circulation; the inconveniences relate to the mercury, for example, stomatitis, gastro-intestinal disturbances, eruptions, brain troubles, and to the method itself, pain, infiltration, fistula, abscess at the site of operation, nervous phenomena, death even from one of the complications.

The indications and contraindications for the use of soluble and insoluble salts have been set forth by Dr. Brocq already in these pages. As to technic, the liquid injected must be chemically pure, filtered and sterilized, and the dose should be the smallest possible. Insoluble salts must be held in suspension in mucilage, or preferably vegetable oil. The emulsion changes quickly in the air and each dose should be separately and recently prepared and placed in a wide-mouthed bottle. Its amount should be double that intended for injection in order to fill the syringe. Cocain is incompatible. The dosage should be based on the body weight (50-100 kilos), on the end sought, on the degree of intensity and resistance of the individual. The sites of injection for soluble salts are intravenous, paravenous, subcutaneous, intramuscular, or subconjunctival; for insoluble salts, intramuscular or subaponeurotic in the deltoid, inter- or subscapular regions or buttocks. The last is the spot most commonly used. The syringe, a Pravaz, with a platino-iridium tip, should be thoroughly sterilized with the skin. The needle may be forced into the tissues alone or attached to the syringe. The former is preferable in any case, since it gives information as to the location of the tip, within or outside the vessels. The needle should penetrate, in intramuscular injection, its whole length. The syringe is then attached and the liquid forced in slowly. The skin should be pinched in withdrawing the tip to avoid leaving

a droplet along its path and so causing an abscess. Finally, the patient is allowed to rest a short time or the spot is lightly massaged. Two formulæ are given for injections: (1) soluble, (2) insoluble.

| (1) | | | | | | | |
|-------------------|---|---|---|---|---|---|-------|
| Hydrarg. bichlor. | . | . | . | . | . | . | 0.005 |
| Sodii chlor. | . | . | . | . | . | . | 0.01 |
| Aq. | . | . | . | . | . | . | 1. |

| (2) | | | | | | | |
|---------------------------|---|---|---|---|---|---|------|
| Sublimed calomel | . | . | . | . | . | . | 0.05 |
| Sterilized oil of vaselin | . | . | . | . | . | . | 1. |

The number of injections varies, as a general rule, for soluble salts. They are given every day or every other day to 30 or 40. For insoluble salts, 6 to 8 injections at intervals of fifteen to twenty days, are sufficient. A different spot should be selected each time.

(A note of warning, previously sounded by Möller, Lesser, Watraszewski and others, and recently reiterated by Schultze (*Archiv. für. Derm. u. Syph.*, May, 1897), by Hartung (*ibidem*, July, 1897), and by Epstein (*ibidem*, August, 1897), in regard to lung embolism occurring as a complication of injections of insoluble salts, is not out of place. The emboli and resulting infarcts are caused by minute particles of mercury or paraffin which, having entered the venous blood stream, lodged finally in the terminal ramifications of the pulmonary vessels. The case reported by Schultze recovered.)

GENITO-URINARY DISEASES.

Infiltrating Neoplasms of the Bladder. PROFESSOR GUYON (*Ann. d. Mal. des Organes Gén. Urin.*, p. 225, 1897).

In a clinical lecture Professor Guyon lays down certain rules of great value for guidance in the management of this class of cases. In these cases of infiltrating cancer it is seldom that the diagnosis can be made early enough to hope that any operative procedure can effect a radical cure. The principal symptom, and generally the one which should awaken suspicion as to the nature of the trouble, hematuria, is only apt to occur long after the pathological process has made considerable headway, and it is seldom that these parietal tumors, at any rate, early in their growth, come to occupy the cavity of the bladder. Instead of this, starting at the epithelial layer, they extend down through the mucosa and spread to and through the muscular coat, involving that, so that it is late in the process that hemorrhages are apt to occur, and these, though sometimes severe, are more often slight in amount. These patients may for long periods of time pass small quantities of blood, not enough to call either the patient's attention or that of his medical attendant to the true state of affairs, and can be discovered only by careful microscopical examination. It is the persistent occurrence of this phenomenon which may be of value in leading to a diagnosis.

Pain and frequency may at times precede or accompany this

slight hematuria, being often so slight as to pass unnoticed. And when combined with a purulent urine, the state of the bladder rendering it susceptible to infection, the case may be looked upon as a simple cystitis. The ease, then, with which, by rectal and bimanual palpation of the empty bladder, the presence of a tumor may be established, testifies to a development well advanced.

It is not in their symptoms alone that parietal tumors differ from pedunculated tumors. These latter are most frequently exclusively vesical, they exist isolated in the cavity of the bladder which they may fill more or less according to the volume to which they attain, and have no tendency to spread beyond their own limits. While the tendency of the parietal tumor is to spread, infiltrating the interstices of the mucous and muscular coats either in a manner readily recognized by the sight or "concealed," by which the extent of dissemination can only be determined by numerous sections for microscopic examination, while they have little tendency to grow out and occupy the bladder cavity.

It is, however, to be noted that these pedunculated growths, in spite of their benign appearance, are themselves often epitheliomata.

Rectal touch, combined with abdominal palpation, is of great importance in the examination of vesical tumors, as it permits us to recognize clinically the consistence of the bladder-wall. However long-standing the tumor may be, suppleness of the bladder-wall is of good import, both as to operative procedure itself and to ultimate results, while thickening of bladder-wall, induration, and inequalities augur badly.

The case serving as the basis of this lecture, a man aged fifty-one years, had in 1893 a gonorrhea lasting two months, which was to all appearance cured without complication, but early in 1896, after prolonged riding, he had a typical epididymitis. At this time there began to be frequency and slight attacks of terminal hematuria. In June, 1896, the hematuria and frequency increased and the urine began to be cloudy. Later, in August and September, the purulency increased, though the hematuria was less. Then after this he began to have severe hematuria, the pain and frequency increased, and he began to fail. At this time he was seen by Professor Guyon. Examination showed the urethra to be free, the bladder emptied itself, and became sensible on the injection of 40 grams of fluid. With the bladder empty, rectal and bimanual palpation showed a normal prostate, while the bladder was found to extend above the pubes, higher on the right side. The walls were thick, indurated, and of irregular contour, showing a large tumor of wide implantation in the right bladder-wall. The urine showed pus, blood-cells, and numerous bacteria, no tubercle bacilli, and small masses of epithelial cells, altered and suspicious. Washings of the bladder showed small masses from which the diagnosis of epithelioma of the bladder was established.

Here was a large tumor, giving a very recent history, so that it was difficult not to believe that it had reached a considerable volume before the first symptoms pointing to bladder trouble occurred.

And in spite of the fact that it must have been already advanced before the onset of symptoms, the frequency and pain does not seem to have been due to the presence of the tumor alone, but to the secondary infection arising as a result of his previous attack of gonorrhea, as this frequency was immediately preceded by an attack of gonorrheal or post-gonorrheal epididymitis. The infection then reaching the bladder found a ready soil, which rendered the arising cystitis persistent and destined to grow worse. This is contrary to the usual course observed in vesical neoplasms. Though they may give rise to frequency, the cystitis was of spontaneous origin. This is not the rule. These tumors evolve, grow, even to filling the bladder, without cystitis arising. This is, however, easily induced, but it is usually induced by the introduction of an instrument not thoroughly sterile.

The present state of the patient, grave hematuria, increasing cystitis, failing powers, called for operative interference. The question arises, does this case present a condition in which a radical operation will give hope of ultimate cure, or is a palliative operation only to be thought of?

A study of 56 pathological specimens was made with a view to the conditions under which propagation of the disease passes to the lymphatics and in what proportion of cases it is likely to be met; also what forms of bladder tumor are likely to have an extension to the lymphatics. This must be learned rather by pathological than by clinical studies. These specimens were divided into three groups. (1) Those in which the glands were preserved. (2) Those in which the condition of the glands at the autopsy was noted. (3) Those where there were no glands preserved or noted.

The first group contained 13, the second 2, and the third 41 specimens. There were 15 neoplasms, then, in which there was extension to the lymphatic glands, in each of which cases the tumor was of the infiltrating variety. Of the 41 specimens, in 20 the tumor had invaded the bladder-wall, 20 were frankly vesical, *i.e.*, peduncular, and 1 showed an implantation which was extensive but not deep. The conclusion is that propagation to the glands is frequent in infiltrating neoplasms.

According to Albarran this has taken place once the neoplasm has passed the limits of the mucosa.

In the case of this tumor, which by rectal touch shows that the walls have been extensively invaded, it can only be feared that the lymphatics have been invaded. Can this be clinically established?

A study of specimens and experiments shows that the glands most commonly invaded are seated along the hypogastric vessels at the level of the bifurcation of the common iliac, a position which can scarcely be reached by rectal touch. So that clinically and pathologically we can only infer that propagation has not taken place when the bladder-wall appears to be intact, and this propagation to the lymphatics is greatly to be feared when with an invasion so manifest is combined a condition which has existed a long time.

The conditions under which the tumor presented itself were such

that it was practically evident that total extirpation of the organ would not destroy all foci of the disease. Even had the patient been seen at the beginning of his symptoms, the tumor would have been too far advanced, in all probability, to hope for a radical cure, so that a palliative operation was all that could be held out to the patient. An early operation being the only one which could give any hope of a total eradication. These parietal tumors, however, call at least oftentimes for the palliative operation. If the pains are such that medication can subdue them, and the hematuria such that it can be controlled, then if late in the course of the disease, it is better to abstain from intervention. But to conquer the severe pains or to modify severe and repeated hematuria, opening of the bladder and partial attack of the tumor is the legitimate indication.

The benefit which these patients may obtain is comparatively real and of use in modifying suffering and prolonging life.

The method of procedure is by a suprapubic cystotomy, and an attack upon the entire surface of the tumor by the curette, by scissors (as these growths do not bleed so much as the pedunculated variety), and by the application of the thermocautery to the entire surface, both wherever the tumor appears in relief and over the surface upon which the scissors and curette have been used. The destruction by the cautery to prove efficacious must be done, so to speak, gradually. It is repeated by light strokes and gradual carbonization of the entire implantation. It is further necessary to go over the ground cauterized two or three times, going over this ground again with the curette, in order to subject the subjacent layers anew to the cautery.

When the destruction appears sufficient, the bladder is generally closed completely, for the pathological tissue lends itself to immediate reunion. This is important, for with secondary reunion there is the risk of favoring the propagation of the neoplasm to the abdominal wound.

Book Reviews.

Diseases of the Skin. JAMES NEVINS HYDE, M.D. Fourth revised edition. Lea Bros. & Co., Philadelphia and New York; 1897.

In reviewing the third edition of Dr. Hyde's book, three years ago, it was said that its successive reprintings were milestones marking the path of dermatological progress. This last has inscribed upon it more new names than appeared on that of '93, and the signpost near by appears to point to broader, better-lighted paths in the regions beyond. It seems a pity the new edition could not have been delayed six months in order to receive the benefit of the researches published in that time, notably Sabouraud's, on seborrhea and alopecia areata. It would have necessitated, probably, a rearrangement in the first subject. If Sabouraud's work at the present writing remains incomplete, he has at least made the position of Unna and his pupils, with regard to the parasite in seborrheic der-

matitis, untenable. The remark applies equally to the work of Elliot and Merrill. Six months would have lengthened into a year in the wait for the most recent work on the xanthomata. While not agreeing with Pollitzer's conclusions regarding diabetic xanthoma, the reviewer would place his work on a par with Sabouraud's in the other two varieties. In passing, we should like to call attention to a misapprehension on the author's part regarding diabetic xanthoma (p. 542). The yellow apex of the nodule is never due to epidermal change. In fact, involvement of the epidermis does not occur except secondarily.

We were rather curious to note the author's treatment of the tuberculosis in view of his wide expansion of the group in his London address last year. Its limits, particularly as to the "dermatoses of scrofulous subjects," are considerably narrowed. The introduction of new plates is noticeable. A cheerful good-bye might be said to more than one of the old friends, whose rounds have never ceased since Kaposi's use of them in his first edition. The remark is peculiarly applicable to his diagrammatic representations of histological preparations. New diseases are considered and much matter, now obsolete, has been removed to make room for the new. We offer our best wishes that the prosperous career of Dr. Hyde's work may remain forever unbroken.

J. C. J.

A Guide to the Clinical Examination of the Blood for Diagnostic Purposes. By RICHARD C. CABOT, M.D. New York: Wm. Wood & Co., 1897.

The profession in English-speaking countries owes the author a pressing, if not an everlasting, debt of gratitude for the first complete treatise on hematology in the language. Previous to its appearance, scattered monographs such as Thayer's of Baltimore on "Malaria" and Stengel's treatise in the Twentieth Century Practice were the only guides, worthy the name, for the beginner. Blood examination has ceased to be an accomplishment; it is a necessity, as much so in dermatological, genito-urinary, and venereal practice as in the field of "internal medicine." Leredde's recent work on eosinophilia in dermatitis herpetiformis, erythema, and psoriasis, is fresh enough in the reader's mind to prove the contention.

To become really expert in blood examination requires long practice, the patience of Job and a nicety of technical skill, which can be thoroughly realized only by those who have attempted it. Dr. Cabot describes every step in minutest detail so that ultimate success is a question only of persevering effort. Book I. treats of examination methods, physiology, and general pathology; Book II. of the special pathology of the blood. The latter is in many instances only in a transition state and its value purely negative. In Hodgkin's disease, for example, the summary is given as "normal blood in early stages, later often marked anemia, sometimes leucocytosis"; the diagnostic value as "excluding leukemia." A chapter is given up to tuberculosis, syphilis, and leprosy. The author appears to doubt the reaction of syphilitic blood to mercury, described by Justus. The

author, expressing his dissatisfaction with existing terminology, describes four stages of growth in leucocytes: small lymphocytes, large lymphocytes, transitional forms, polynuclear neutrophiles, and eosinophiles. He is careful to define each of the pathological forms in both white and red corpuscles so there is no possibility of mistaking the meaning. The appended bibliography covers forty-six pages. The colored illustrations are of the greatest value, but Funke, the lithographer, has hardly reached the standard he set for himself in Thayer's monograph. J. C. J.

De La Dyshidrose (Dysidrosis). DR. PAUL FAREZ. A. Maloine, Paris; 1897.

Occasionally there reaches us a *Thèse de Paris*, which, were the space available, in the interests of the JOURNAL's readers, would be reproduced in full in these pages. This is such a one. The whole range of this interesting controversy is passed over, from the time of the famous discussion of Tilbury Fox and Hutchinson, and every contribution of value is to be found in the appended bibliography. A complete index to a given subject is a priceless possession in medicine, since it saves the labor of any search through literature previous to its publication. Anyone who has undertaken such a task will realize the force of the remark.

Indicating the author's acceptance of the identity of dysidrosis (Fox, Crocker) and pompholyx (Hutchinson), and his preference for the latter term, we reach the author's conclusions:

"I. It may be considered as definitely proved:

"1. That dysidrosis is not situated in the sudoriparous apparatus.

"2. That the vesicular process is developed in the intercellular spaces of the prickle-cell layer.

"3. That the vesicular contents is constituted of elements which have transuded through the vascular walls of the superficial papillary network.

"II.—It appears, moreover, probable that this exudation results from inflammation of these same papillary vessels.

"III.—Finally, many reasons make the assertion very likely,

"1. That the papillary inflammation is caused by a momentary exacerbation of a chronic vasomotor derangement due to a general intoxication of the nervous system.

"2. That dysidrosis, supposing at once a nervous, vasomotor and toxic basis, may be defined as a toxineurodermitis or a vasomotor toxic dermatosis."

The work concludes with a report of thirty-five cases, culled from the literature or the author's own. J. C. J.

BOOKS RECEIVED.

Pathogenese der Mercuriellen Stomatitis und Salivation. DR. ALFRED LANZ. Oscar Coblentz, Berlin; 1897.

Norkiskt Medicinskt Archiv. Festband, No. 38. Norstedt & Söner, Stockholm; 1897.

- Traité Pratique des Maladies Vénériennes.* DR. HENRI BERDEL. A. Maloine, Paris; 1897.
- Przegląd Chirurgiczny.* Edited by DR. W. H. KRAJEWSKI. Tom III. Warsaw; 1897.
- Chirurgie des Voies Urinaires.* DR. E. LOUMEAU. Feret et Fils, Bordeaux; 1897.
- Om Endocardit.* DR. FRANCIS HARBITZ. Christiania; 1897.
- Over the Hookah.* G. FRANK LYDSTON, M.D. Chicago; 1896.
- Transactions of the New York State Medical Society, 1897.*
- Johns Hopkins Hospital Reports.* The Johns Hopkins Press: Baltimore, 1897. Vol. VI.

Multiple Sarcoma of the Skin. DIABELLA (*Wien. klin. Wochenschr.*, No. 22, 1897) reports a case combined with lymphocytosis in a man whose disease began with swelling of the submaxillary, cervical, inguinal, and axillary glands, and small, painless tumors, numbering about 100, scattered over the body. The disease was diagnosed as multiple, pigmented, idiopathic sarcoma of the Kaposi type, and numerous hemorrhagic pseudosarcomatous growths arose from the original tumors. The patient died. Ten blood examinations showed hemoglobin, 69 to 73 per cent.; erythrocytes, 4,000,000 to 4,545,000; leucocytes, 20,400 to 36,000. Of the white cells, there were 88.4 to 95.7 per cent. of mononuclear, 3.89 to 11.09 per cent. of polynuclear, and 0.28 to 1.10 per cent. of eosinophiles. This is a high grade of lymphocytosis, of a form purer than in any other disease. This increase is at the expense of the polynuclear cells. An experimental injection of diphtheria antitoxin produced a marked diminution of lymphocytes in a few hours. The same result was obtained in a case of lymphatic leukemia.

Lesions Apparently Tuberculous Cured by Antisyphilitic Treatment. ALFRED FOURNIER (*La Médecine moderne*, May 22, 1897) brings forward this subject at a meeting of the French Society of Dermatology and Syphilology, the case being that of a man in whom a history of syphilis seemed to be excluded, who had a history of general tuberculosis in addition to the cutaneous ulcerated granulomata. Under one injection of calomel subcutaneously there was improvement in the lesions of the skin, and under a few more injections he was nearly cured. Augagneur of Lyons confirmed the views suggested by Fournier, citing two similar cases. Jacquet also reported a case, that of a young woman recently confined, who, after puerperal fever, developed acute osteomyelitis of the left thigh so grave that Dujardin-Beaumetz thought of proposing amputation, but under Gibert's syrup the woman recovered completely. Fournier thinks that the moral to be drawn from such cases is that mercury and iodine cannot be regarded as reactive drugs, proving the existence of syphilis.—*Univ. Med. Mag.*



ILLUSTRATING DR. FORDYCE'S ARTICLE ON
DERMATITIS HERPETIFORMIS.



FIG. 1.—*Spencer* $\frac{1}{2}$ in. Compensation Ocular 4, *Zeiss*. Dermatitis herpetiformis, showing circumscribed miliary vesicle containing polynuclear leucocytes in lowermost rete layers.

(ILLUSTRATING DR. FORDYCE'S ARTICLE)



FIG. 1.—*Spencer* $\frac{1}{2}$ in. Compensation Ocular 4, *Zeiss*. Dermatitis herpetiformis, showing circumscribed milium vesicle containing polynuclear leucocytes in lowermost rete layers.

(ILLUSTRATING DR. FORDYCE'S ARTICLE)



FIG. 2.—*Spencer* $\frac{1}{2}$ in. Compensation ocular 4, *Zeiss*. Dermatitis herpetiformis, showing vesicle formation in the epidermis communicating with the cell infiltration in the derma. The epidermis is thickened in both instances.



FIG. 2.—*Spencer* $\frac{1}{2}$ in. Compensation ocular 4, *Zeiss*. Dermatitis herpetiformis, showing vesicle formation in the epidermis communicating with the cell infiltration in the derma. The epidermis is thickened in both instances.



FIG. 3.—*Spencer* 1 in. Projection ocular 2, *Zeiss*. *Pemphigus vegetans*, showing thickening of the interpapillary rete processes. The presence of a miliary vesicle in the epidermis is shown on the right which is similar to those met with in dermatitis herpetiformis.

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Original Communications.

REPORT OF A SEVERE CASE OF DERMATITIS HERPETIFORMIS, PRESENTING MANY OF THE FEATURES OF IMPETIGO HERPETIFORMIS.¹

By JOHN A. FORDYCE, M.D.,

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Visiting Dermatologist to the City (Charity) Hospital, etc.

A NUMBER of cutaneous affections presenting multiform lesions, arranged in a marked herpetiform manner, with a tendency to disappear and recur at irregular intervals, usually accompanied by intense itching and burning, and of rather obscure etiology, have been recognized by dermatologists under various names for many years.

We are indebted to Professor Duhring for a critical consideration and analysis of this group of diseases, and for the general term which is at present usually employed to designate them.

The form and intensity of certain eruptions on the skin is influenced not only by the condition of the individual, but also by a peculiar reactive power to irritants, which may be of a passing or permanent character.

It is known that the same cause, acting on different individuals, may give rise to different eruptive types, and that totally dissimilar causes may produce eruptions which are difficult to differentiate by their clinical features alone.

Many etiological factors have been invoked to account for the group of diseases designated under the collective name of derma-

¹ Read before the Twenty-first Annual Meeting of the Dermatological Association, held at Washington, D. C., May 4, 5, and 6, 1897.

titis herpetiformis, and it is not at all probable that any one definite cause will be found to explain so large a variety of lesions occurring in so many different pathological states.

The serious and generally fatal condition described by Hebra and Kaposi under the name of impetigo herpetiformis is, at the present time, considered by the majority of dermatologists as an affection quite distinct from Duhring's class of diseases. Cases are, however, met with in practice which have many clinical features in common with both types of eruption, and it is sometimes difficult to determine to what class they should be assigned.

The case here reported is of this kind, presenting some of the more serious phases of the multiform affection, dermatitis herpetiformis, most of which correspond closely with the classical features of Hebra's impetigo herpetiformis.

History of the Case.—A. H., aged sixty-six, was born in France. His family history is negative. He was admitted to my service at the City Hospital early in December, 1896, and gave the following history:

He has never had syphilis or any serious illness. He is a moderate drinker of beer and light wines. About forty years ago he stumbled and abraded the anterior surface of his left leg. The injured skin was soon surrounded by vesicopustules, which rapidly became encrusted. After a few days the crusts fell off, leaving the skin somewhat discolored, but otherwise normal. He has had many recurrences of a similar eruption during the last forty years, but always confined to the anterior surface of the injured leg.

His present trouble began early in December, 1896, as an intense pruritus over the right leg. This was followed by an outbreak of grouped vesicles over the hyperemic surface, which followed the scratching.

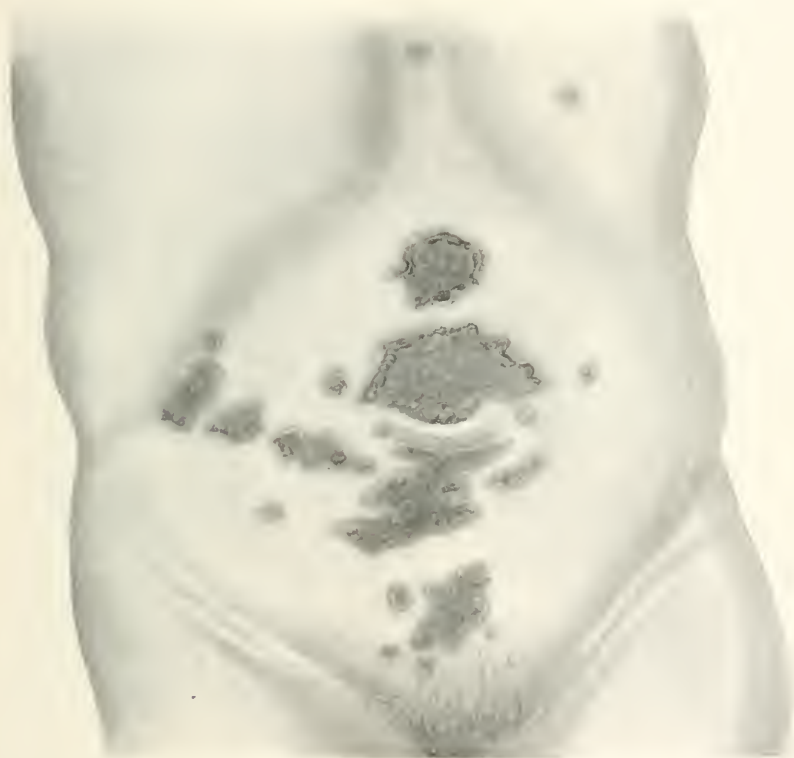
The vesicles showed a marked tendency to group themselves in circular forms. Some vesicles remained as such, while others rapidly changed into pustules.

The eruption of grouped vesicles and vesicopustules rapidly extended over the entire leg, a part of the thigh, and, in turn, invaded the opposite lower extremity. The arms and forearms were next involved, then the abdomen and gluteal region.

The extension of the eruption was accompanied by intense itching, which interfered with the patient's sleep, appetite, and general nutrition. When a fresh crop of vesicles appeared it always assumed a grouped or circular arrangement; now and then, however, single vesicopustules appeared near the advancing margin of a group.

When the patient was admitted, the legs below the knees, the lower half of the thighs, and the greater part of the forearms were the seats of a confluent eruption, which was made up of vesicles, pustules and papules, studded with pin-head-sized pustular points. There was a seropurulent discharge from the extensive eruption, which was quite offensive, owing to the absence of a proper dressing.

FIG. 4.



Showing some of the earlier herpetiform lesions.

The best illustration of how the eruption began and extended is obtained in the appearance of the lesions on the anterior and inner surfaces of both thighs (colored plate), on the abdomen, surrounding the umbilicus, and over the suprapubic region (Fig. 4). Here the eruption consisted of a number of irregularly rounded plaques, from half an inch to six inches in diameter, which were made up of multiform lesions, extending in a peripheral manner.

The margins of the patches were covered by crusts from the drying, purulent secretion, while the centers of the larger plaques showed a tendency to clear. The greater part of these grouped lesions included by the crusted borders consisted of conical papular elevations, intermingled with which were vesicular and pustular lesions. On passing the finger gently over one of the patches, the skin was found to be thickened, and the elevation, for the most part, solid. Outlying single pustules and small groups of vesicopustules were situated about the larger groups.

The uvula was red, swollen, and the seat of a superficial lesion, having a grayish base and dark-colored edges. No other mucous membrane lesions were detected.

The urine was found to have a specific gravity of 1013; reaction, acid; no sediment. A trace of albumin was found, but at this time no casts. The patient was fairly well nourished; could eat moderately, but was greatly distressed by the severe and continuous itching.

After he had been in the hospital for ten days, under the application of a ten-per-cent. ichthyol salve, a number of the large patches partially disappeared, leaving a slight thickening of the skin, some confluent papules, together with a brownish-red discoloration. The colored drawing, made on January 2d, shows the change which took place in the large plaque, situated below Poupart's ligament. (Drawing shown at the meeting.)

The forearms and legs, however, changed little in their objective signs, excepting a diminution in the amount of the discharge.

About this time, January 2d, a decided change for the worse occurred in the patient's condition. He developed a fever which ranged for about two weeks between 100° to 101° F. in the mornings to 101.5° to 102.5° in the evenings. Unfortunately, the temperature and pulse chart, which was carefully made, was destroyed by a careless nurse.

Shortly after the beginning of this exacerbation of the symptoms, the feet became much swollen, and over their dorsal surfaces large bullæ formed, the contents of which soon became cloudy. New groups of vesicopustules formed over the thighs, abdomen, and back, which extended in the same manner as those first seen.

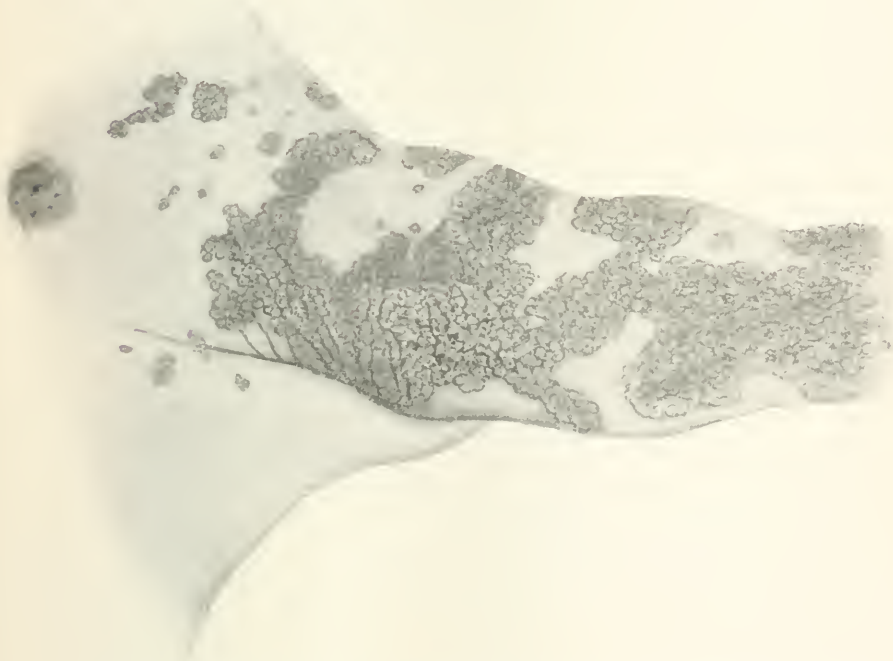
Erythematous and urticarial lesions, together with groups of papulovesicles, came out over the back and gluteal regions.

He became very weak, was unable to retain nourishment, and vomited repeatedly for several days. His pulse was rapid and irregular, and his recovery from the attack was considered doubtful.

His urine contained a larger amount of albumin, some epithelial and granular casts. The amount of urea excreted showed no material reduction, and no decided uremic symptoms were present, aside from those referred to. His condition gradually improved until January 23d, three weeks after the beginning of his serious symptoms, when he was obliged, by reason of some business trouble, to leave the hospital.

On the day he left the water-color drawing was made (repro-

FIG. 5.



Showing papillomatous growths which developed at the sites of the vesicopustular lesion in axilla and on the arm.

duced as Figure 5 in the text), which shows a marked development of papillomata in the right axilla and inner side of the arm. A similar condition was present over the left arm and, to a slight extent, on the legs.

He returned to the hospital on the 18th of February, and stated that during his absence he had been able to go about and attend to his business with a fair degree of comfort. The eruption gradually became less profuse, but did not entirely pass away. The

itching and burning sensations caused very little annoyance. The only local application made use of was sweet oil, applied to the more troublesome areas.

On his return, the only acute lesions were a few scattered vesicles about the ankles. The sites of the former eruption, however, were marked by large, pigmented areas, which were quite smooth and free from any scarring.

Two days after the second admission to the hospital innumerable lesions, grouped and single, came out over the pigmented areas, accompanied, as before, with intense itching and burning.

The circular outline and grouping of the papulovesicles on the pigmented skin is shown in Figure 6 (made from a colored drawing). The palms and soles were not involved, with the exception of a few bullæ on the left sole.

The application of a ten-per-cent. solution of ichthyol in oil gave immediate relief to the distressing itching. This dressing was found to be superior to solutions and ointments of various kinds which had been previously applied.

The quantity of urine was found to be reduced at the time of this third attack, being only twenty ounces in the twenty-four hours. Under the use of alkaline diuretics, the amount increased to eighty ounces in twenty-four hours, and the urea to over 500 grains. Albumin, granular and hyaline casts were still found.

Examination of the blood, made at various times, showed a great increase in the number of eosinophile cells. In the serum from the vesicles the eosinophiles were very numerous, fully half of the cellular elements being of this character.

Cultures from recently developed and unbroken vesicles made at the Carnegie laboratory developed a growth of *staphylococcus albus* and *aureus*. It is probable that the organisms were a secondary infection, as they were not found in sections stained by Gram's method, methylene-blue, etc.

The patient remained in the hospital until March, when he was discharged, at his own request, somewhat improved. He was lost sight of until early in October of the present year, when he called at my office and gave the following report of his condition:

Acting on the advice of a friend, he took, in the early spring, several doses of a decoction of jaborandi, which was followed by profuse sweating, and by a disappearance of the eruption. He remained free from itching and skin trouble for about three months. Then he began the use of warm baths. After taking three or four of them, the eruption reappeared over the trunk and extremities,

and gave him a great deal of annoyance for a period of a month. It then left the chest and back, but remained on the legs up to the time of his visit to me.

FIG. 6.



Large pigmented area following the disappearance of the eruption shown in the colored plate, on which circinate vesicular lesions developed.

His condition at this time (October 11th) is as follows: He is extremely anemic, quite feeble, and has the waxy look peculiar to cachectic conditions.

Almost the entire body is the seat of a diffuse and patchy pigmentation, which marks the sites of the former eruption. Numerous scratch marks, and some superficial pits, are irregularly distributed over the surface.

A papulovesicular and pustular eruption is present on both legs below the knees, which is diffuse, with the exception of a few outlying, rounded patches. The right leg is swollen to twice the size of the left, the swelling consisting of a hard edema, like that met with in elephantiasis. Papillary outgrowths are present over the lower third of both legs and the dorsal surfaces of the feet.

There is a moderate discharge of seropurulent fluid, with an offensive odor, from the eruption on the legs.

The patient states that his appetite is fairly good, and that during the past two months he has gained in strength. His urine, examined at this time, was dark in color, had a specific gravity of 1022; it was acid in reaction, and contained the faintest trace of albumin; indican was not present.

Histology.—Several small lesions, including a number of minute vesicopustules, which had existed for from twenty-four to forty-eight hours, were excised and fixed in absolute alcohol, and in a four-per-cent. solution of formalin, followed by alcohol. The surface epithelium covering the vesicles was unbroken, and the lesions themselves were quite deeply seated in the epidermis. The most active pathological change was found in the papillary region of the corium, and in the deep layers of the epidermis.

The epidermis was found to be considerably thickened, and invaded by numerous polynuclear leucocytes and Langerhans' cells.

The interpapillary processes, as shown in Figures 1 and 2 (plates), extend for some distance into the underlying corium. The stratum corneum and stratum granulosum also show some degree of thickening.

Several miliary vesicles were found in the deep layers of the rete containing large numbers of mononucleated and polynuclear leucocytes in about equal proportion. The epithelium was absent at the sites of the vesicles, while that limiting the vesicles was invaded by the wandering cells. (Figs. 1 and 2, plates.) In Figure 2 a minute vesicle is shown on the left of the larger one, which is evidently due to the invasion of the neighboring epithelium by cells which have migrated from the older lesion.

The corium directly below the vesicle formation is densely invaded by cells of a similar character, together with fragmented nuclei, and a number of eosinophile cells. In sections stained with methylene-blue and eosin the eosinophiles can be made out with more or less distinctness.

Sections so stained, however, did not show the epidermal vesicle, so that their presence in the epithelium was not demonstrated.

The entire papillary area was infiltrated with leucocytes, but to a less marked degree than in the situations mentioned. In the middle region of the corium numerous dilated vessels were surrounded by mononuclear and polynuclear cells, the former class being in excess.

A few vessels in the deeper layers of the derma, and those accompanying the sweat-ducts and coils, were found to be slightly involved in the inflammatory process. The intensity of the inflammatory action is greatest in the papillary region of the corium, where the sudden effusion of so much serum and so many leucocytes, readily effected an entrance between the epithelial cells, with the resulting formation of vesicles.

In a case of pemphigus vegetans, of typical appearance and localization, seen by me at the City Hospital several years ago, the tissue was excised from which the photograph (Fig. 3, plate) was made.

Here a miliary vesicle in the epidermis is seen on the right of the plate, which, under a higher power, is found to be filled with exudation-cells of the same character as those referred to in the case first described.

The primary seat of inflammation in this case, however, is in the region of the coil-glands. Here a dense mass of leucocytes is found, mostly of the mononuclear type, surrounding these structures, while the glandular cells themselves are swollen and degenerated. The inflammatory material extends along the sweat-ducts to the papillary region of the derma, and at this point the epidermic vesicle is formed.

The hypertrophy of the epidermis is greater than in the case of dermatitis herpetiformis, the section being less highly magnified than those shown in Figures 1 and 2.

The primary focus of inflammation in this case of pemphigus vegetans is deeply seated about the coil-glands, while in dermatitis herpetiformis the papillary layer of the corium is primarily affected.

A more extended study of this rare form of pemphigus, in con-

nection with dermatitis herpetiformis, may subsequently be undertaken, and further differences in their histological structure pointed out.

The pathological findings in my case differ somewhat from those mentioned by Gilchrist,¹ although in both cases the chief lesions were in the papillary region. The vesicles in his case were seated below the epidermis, while in mine they were intra-epidermic.

In both cases the same character of inflammatory cells was encountered, *viz.*: polynuclear, mononuclear leucocytes and eosinophiles.

Since the presence of eosinophile cells has been demonstrated in so many pathological processes much of the diagnostic significance of their increased numbers in dermatitis herpetiformis, as claimed by Gaston, Leredde and others, has been lost.

In Gilchrist's article (*loc. cit.*) the meager literature pertaining to the pathology of Dühring's disease is briefly referred to. Both Gilchrist's investigation and my own agree in demonstrating a very acute inflammatory process, in this respect showing a marked contrast to Unna's² description of the lesions.

In his own, as well as in preparations from Dr. Elliot's³ cases, he emphasizes the absence of leucocytosis, and refers in no way to the presence of eosinophiles.

The examination made by Du Mesnil⁴ of excised tissue from a case of impetigo herpetiformis showed the location of the minute vesicle to be in the superficial portion of the rete. The vesicular contents were composed of leucocytes, epithelial cells, and serum. The papillary area was the seat of greatest intensity of the inflammatory process. The histological findings in this case correspond closely to those in my own.

The papillary outgrowths in my case (Fig. 5), which developed at the sites of the early vesicles and pustules, have been observed in other cases of Dühring's disease (Hallopeau and Monod⁵), as well as in many other vesicular, pustular, and bullous eruptions.⁶

¹ "The Pathology of a Case of Dermatitis Herpetiformis, Dühring," *Johns Hopkins Hospital Reports*, vol. 1, p. 365.

² "The Histopathology of the Diseases of the Skin," translated by Norman Walker, 1896, p. 140.

³ *New York Medical Journal*, 1887.

⁴ Du Mesnil und Marx, Ueber, "Impetigo Herpetiformis," *Archiv. f. Dermat. u. Syph.*, p. 657, 1889.

⁵ *Ann. de Dermat. et de Syph.*, 1895.

⁶ See Art. "Ueber Impetigo Contagiosa Vegetans, Zugleich ein Beitrag zur Pathologie des Protoplasmas der Epithelzellen," Karl Herxheimer, *Archiv. Dermat. u. Syph.*, B. xxxviii, Heft 2,

In impetigo contagiosa, complicated with papillary development, and in pemphigus vegetans, Herxheimer (*loc. cit.*) was able to demonstrate, in the middle layers of the rete Malpighii, a zone of epithelial cells, in which the protoplasm remained unstained after the use of various reagents, while the nuclei readily took the stain.

The author believes this peculiar degeneration of the epithelium in bullous affections may be the first change indicating the subsequent development of vegetations.

I was unable to confirm the observation of Herxheimer in either of the cases mentioned in this paper.

Kaposi,¹ in this and other publications, strongly denies the necessity for the use of the general term proposed by Duhring, believing that the affections so designated are sufficiently well described by the older names—erythema multiforme, pemphigus pruriginosus, pemphigus, etc.

He is firmly convinced that impetigo herpetiformis, in its symptomatology, course, and etiology, is an affection entirely distinct from any other, and should be given a definite place in dermatological nomenclature.

My chief reason for reporting the foregoing case, aside from its intrinsic interest, is that it seems to justify the claim which Duhring originally made, *i. e.*, that impetigo herpetiformis should be included under his general designation.

In localization, herpetiform arrangement, peripheral extension, severe general symptoms, fever, chills, marked impairment of the health, and in the great preponderance of pustular lesions, the case reported corresponds closely with impetigo herpetiformis.

The latter disease, which at first was thought to be confined to pregnant or puerperal women, or those suffering from uterine ailments, has been observed in the opposite sex.

In one of Kaposi's (*loc. cit.*) cases, occurring in a man, in addition to the primary miliary pustules, on which he lays great weight in diagnosis, erythematous and urticarial lesions, together with intense itching, were also met with.

My case, however, differs from the majority of cases of impetigo herpetiformis, in the variety of primary lesions, in the absence of pronounced changes in the mucous membrane, and in the distressing subjective sensations of burning and itching.

Both affections show a decided tendency to recur, and, while im-

¹ "Impetigo Herpetiformis," *Vierteljahr. f. Dermat. u. Syph.*, p. 273, 1887.

petigo herpetiformis usually terminates fatally, deaths are not unknown as a result of dermatitis herpetiformis.¹

I am inclined to agree with Besnier that impetigo herpetiformis is not a distinct entity, but the cutaneous expression of a variety of conditions.

If the term pemphigus be limited to a bullous eruption, pure and simple, this definition would exclude the multiform affection described in the foregoing report.

An unprejudiced observer, however, will have to admit that there are no hard-and-fast lines separating these various groups of diseases, but that intermediate and transitional types of eruption are met with which present features common to them all.

Names of diseases, after all, are of little importance when their etiology and pathology are so imperfectly understood.

66 Park avenue.

A CASE OF IMPETIGO HERPETIFORMIS.²

By M. B. HARTZELL, M.D.,

Instructor in Dermatology, University of Pennsylvania.

ON March 31st, 1896, I was asked to see Mrs. M. E. H., a widow, aged 84, on account of a cutaneous affection, from which she had been suffering for the preceding two months. Upon examining her, there were found, upon the outer and posterior surface of the thighs, upon the lower part of the abdomen and back, upon the flexor surface of the arms, a number of quite thickly crusted patches, irregularly oval in shape, and surrounded by a bright red border an inch or more in breadth, upon which were innumerable pin-head- to split-pea-sized, mostly the former, discrete, flat, flaccid pustules. In addition to the pustules about the borders of these crusted patches, there were numerous discrete, pin-head-sized ones, seated upon a reddened base, scattered over the limbs and lower part of the trunk, together with a considerable number of dime- to dollar-sized, irregularly-outlined groups, the larger of which were beginning to crust over in the center. The face and feet were entirely free from eruption, and the hands nearly so. Few or no subjective symptoms were complained of at this time, but there had been itching of moderate

¹ "Pathologie et Traitement des Maladies de la Peau," Kaposi. "Traduction Avec Notes et Additions," par MM. E. Besnier et Doyon, tome premier, p. 548.

² Read at Twenty-first Annual Meeting of the American Dermatological Association, Washington, D. C., May 6th, 1897.

severity for a short time earlier in the disease, when the eruption was first coming out. The patient, as well as the members of her family, were quite positive that the character of the disease had undergone no essential change since its first appearance; the eruption had consisted of small pustules from the very beginning, and had never disappeared, but had slowly spread until it had involved the regions above mentioned. The early history of the disease was briefly as follows:

In the latter part of December, 1895, the patient's tongue became very sore, being covered on the sides and under surface with what were called by the patient's family blisters, and continued so some weeks. Before the tongue was entirely well—about the end of January, 1896—the present eruption, unaccompanied by any constitutional disturbance, began to appear upon the skin, first upon the lower extremities, a little later upon the abdomen and arms.

At the time of my first examination the tongue showed no eruption of any kind, but was abnormally smooth, bright red, and raw-looking in the center, milky-white upon the sides, as if painted with nitrate-of-silver solution; but it was not painful, as it had been in the beginning, when the pain was so great as to interfere seriously with the taking of food. Apart from the skin affection, the patient seemed in excellent health, and, notwithstanding her very advanced age, was quite active; indeed, I first saw her at the house of one of her friends, a considerable distance from her home, where she had gone to spend the day. I saw her again, one week later, when it was evident that the eruption was spreading more rapidly than it had done heretofore; there were many new discrete and grouped pustules, and the old patches were enlarging, always surrounded by the border of small pustules already spoken of. An examination of the urine revealed the presence of a small quantity of albumen, but no sugar. The appetite, which up to this period had been good, was markedly diminished. For a period of one week there was but little perceptible change, either in the skin or in the general condition of the patient, who spent the greater part of the day sleeping, but was easily aroused to take nourishment, and when awake seemed cheerful and fairly comfortable. On April 14th, however, there was a sudden outbreak of innumerable pin-head- to shot-sized pustules over the entire trunk, hands, feet, and inside of the thighs, the face and scalp being spared; and, coincidentally with this outbreak, the temperature, which had been hitherto unaffected, began to rise slightly, being 100° F. in the morning. There was now considerable discomfort from soreness and burning, and during the next four or

five days the eruption slowly spread to the neck, face, and scalp, regions which up to this time had been entirely exempt. Along with this new eruption upon the skin, a few shot-sized lesions, with cloudy contents, appeared upon the tongue, which ruptured within a few hours after their appearance, leaving shallow ulcers, which were not long in healing. This eruption upon the tongue gave the patient little or no inconvenience, and lasted but a day or two. On the morning of April 21st, there was a violent chill, followed by symptoms of collapse, the pulse becoming very feeble and irregular. The entire trunk and extremities were now covered with innumerable pin-head- to shot-sized pustules, the skin between the lesions being a bright red; upon the lower extremities the eruption was so abundant as to form a practically continuous sheet, so that the upper layers of the epidermis were separated from the lower by a thin sheet of pus. It should be mentioned in this connection that the pustules did not enlarge after their appearance, but maintained their original size, so that large areas of skin were involved, not by the the enlargement and coalescence of the lesions, but by the springing up of new pustules between the old ones. The patient was now seen by Dr. Duhring in consultation, who quite agreed in the diagnosis of impetigo herpetiformis. Two days later (April 23d), coincidentally with an increase of the eruption upon the face and scalp, there was another violent chill; the conjunctivæ became inflamed, adding much to the patient's discomfort, and a mild diarrhea set in. For the next three days new pustules continued to appear upon all parts of the trunk, extremities, and scalp, a few again making their appearance upon the tongue. The bowels continued loose, with occasional incontinence of urine and feces, and the temperature increased, reaching 102.8° F. The patient's condition now became extremely grave; she was stuporous, being roused with difficulty; the bowels and bladder were evacuated involuntarily, the pulse was feeble and irregular, the respiration somewhat labored. On April 27th there was a decided improvement in the skin; it was much paler, beginning to exfoliate upon the palms and soles, and new pustules no longer appeared. There was a slight change for the better, too, in the patient's general condition; the temperature had fallen to 99° F., and the pulse had increased in strength and volume. But this improvement was of very brief duration, for within the next twenty-four hours a few new pustules were noticed, and shortly numerous ill-defined groups appeared upon the legs; the evening temperature rose to 104°, and it soon became evident that a new outbreak was impending. Before this was fully developed the patient became

profoundly comatose, and died. An autopsy was not obtainable. The treatment was entirely symptomatic, and consisted, for the most part, in the administration of stimulating and supporting remedies, together with abundance of easily digested and assimilable nourishment. Locally lotions of carbolic acid and resorcin were employed for the relief of the burning, which was at times an annoying symptom; later these were replaced by an ointment containing fifteen (15) grains of precipitated sulphur and $\frac{1}{2}$ dram of boric acid to the ounce.

To recapitulate briefly the salient features of the case we have: A pustular eruption of several months' duration, characterized by a marked tendency to occur in groups, to form crusted patches surrounded by a border of miliary pustules, and to appear in successive outbreaks; a coincident eruption upon the lingual mucous membrane; the occurrence of septic symptoms, such as chills, elevation of temperature, diarrhea; and, finally, death, as the direct result of the malady.

Under the title of *impetigo herpetiformis* twenty-one cases have been reported by sixteen observers; but of these some certainly, others probably, should be rejected as being examples of some other form of disease. The case reported by Pataký as occurring in a young man, eighteen years of age, with urethritis, is regarded by Kaposi as having been a bullous erythema multiforme. In the cases reported by Heitzman, Schwarz, and Zeissler the impetiginous eruption was replaced by, or associated with, bullæ, so that the patient died with the symptoms of pemphigus. Whether these are to be regarded as true cases of *impetigo herpetiformis* will depend upon what we consider essential features of this disease. If, as Kaposi maintains, only those cases should be designated with this title in which the eruption is pustular from beginning to end, then those in which bullæ formed a part of the eruption must be excluded from this category; but this, perhaps, is taking quite too narrow a view of the malady.

Of the entire number of cases reported eighteen were women, three men. Before Kaposi's report of a case in a male, in 1887, the disease was thought to occur exclusively in women; more recently Dubreuilh has published another case occurring in a man, which terminated fatally. In one-third of all the cases two or more attacks occurred; and in one observed by Du Mesnil and Marx no less than four, the fourth proving fatal. Of the eighteen female cases two-thirds occurred during pregnancy or the puerperium. In connection with this fact the case reported by Schulze is of interest. The first attack began during the patient's sixth pregnancy, and continued,

for two years. During this attack a seventh pregnancy took place, and, coincidentally, improvement in the eruption. When the patient became pregnant for the eighth time there was no cutaneous complication; but in the ninth pregnancy there was a new attack, from which recovery took place after six-months' duration. At a recent meeting of the Dermatological Society of Moscow Serenin reported a case occurring in a woman fifty-eight years old, in whom an eruption typical of impetigo herpetiformis began on the little finger and thumb of the left hand subsequent to an insignificant injury, whence it spread gradually to other parts, involving the entire cutaneous surface eventually, and causing the patient's death. In 42.8 per cent. the mucous membranes of the mouth were also involved in the eruption, usually some time after the appearance of the cutaneous lesions, but in a few cases, as in my own, some days or weeks before. In the same percentage of cases, *viz.*: 42.8, there was more or less marked albuminuria; this seems to have been due to the cutaneous malady, and not to any independent disease of the kidneys. It is particularly worthy of note that of the seven fatal cases in which there was an autopsy tuberculosis in some form was found to exist in three—in one in the larynx, in another in the lungs, and in the third in the peritoneum. In one of the two cases reported by Auspitz under the name herpes vegetans, which some authors believe properly belong to impetigo herpetiformis, there were repeated hemopoeitic attacks. Notwithstanding the opinion commonly expressed in favor of the septic character of the malady, in but a single instance was any evidence of a septic origin disclosed by autopsy; in this case there was evidence of septicemia, originating in a purulent endometritis. It seems to me probable that the septic symptoms, such as chills, fever, diarrhea are due to absorption of purulent material from the skin, since these are usually observed only after the disease is fully developed.

Du Mesnil and Marx examined excised lesions microscopically, but found nothing more than the ordinary changes seen in inflammations of the skin; cultural investigation showed the staphylococcus pyogenes aureus in great abundance, but no specific organism. Inoculations with pus taken from the pustules were likewise without result.

Of the whole number of cases reported twelve, or 57.1 per cent., died; but the prognosis is not so unfavorable as this large percentage of deaths would seem to indicate, since of these twelve only eight died in the first attack, almost 20 per cent. of the whole number having survived one or more attacks.

A CASE OF HERNIA TESTIS¹

By GARDNER W. ALLEN, M.D.,

Surgeon, Genito-Urinary Department, Boston Dispensary;

AND

FREDERICK J. COTTON, M.D.,

Boston, Mass.

BENIGN fungus of the testicle was first described by Lawrence in 1808. It is the result of a circumscribed inflammation near the surface of the testicle involving the tunica albuginea and overlying tissues, which rupture successively. The testicle thereupon protrudes through the opening thus made. Sometimes the entire organ is found outside the scrotum, leaving the epididymis behind. The skin behind the mass becomes thickened and indurated, forming a tough fibrous ring, while the tunica vaginalis and albuginea are retracted. Sometimes the tumor attains large size through the formation of new tissue and exuberent granulations.

Burnett says that syphilis is considered to hold first place in the etiology of fungus testis and that there is a decided difference of opinion among authors in regard to tuberculosis as a cause.

According to Curling it is usually the result of chronic orchitis, in which there is an exudation of "lymph" in the connective tissue between the tubules; but he says that it occurs occasionally in acute or during an acute exacerbation of chronic orchitis. In such cases it is probably the result of sepsis due to some micro-organism which has found its way from the urethra and has caused local infiltration and coagulation necrosis.

A case reported by Bogdan (*Ann. de Derm. et Syph.*, 1893, p. 1211), in which there was gangrene of both testes, but without hernia, apparently originated in a septic urethral infection, although no cultures were taken.

The case I have to report appears to belong to this class.

J. C., twenty years old, came to the Boston Dispensary February 20, 1897, with a long-continued gleet and what appeared to be an ordinary epididymitis of three-weeks' duration, with marked enlargement of the cord. Four days later a prominent swelling as large as a hazelnut was seen over the front of the testicle, just above the globus minor. It was conical in shape and the overlying

¹ Read at the Annual Meeting of the American Association of Genito-Urinary Surgeons, Washington, D. C., May 5, 1897.

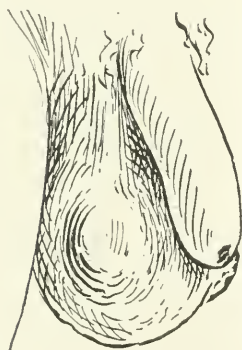
skin looked thin and tense. It resembled a tubercular abscess of the epididymis. Upon incision there appeared one or two drops of thin pus and a bulging out of soft, yellowish-gray, spongy tissue which suggested testicle and proved to be such. Swab cultures were immediately taken.

During the next few days there was considerable sloughing of the skin, exposing more of the necrotic mass. Testicle and epididymis were not distinguishable. There was no pain and no testicular sensation on pressure.

February 26.—Piece of necrotic tissue removed for microscopic examination. The slough is superficial.

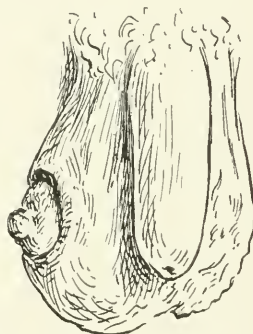
March 4.—The swelling of the cord is decreasing as is also the total mass, and the epididymis is recognizable. The appearance of the partially protruding testicle at this time is shown in Fig. 8.

FIG. 7.



Before incision.

FIG. 8.



Protruding hernia testis.

Opening enlarged by slitting up the cavity of the tunica vaginalis at the top for about three-quarters of an inch.

March 23.—The case has been progressing slowly. All the sloughing tissue has separated and the pockets representing the tunica vaginalis are filling up with granulations. The hernia testis is now reduced in size and presents a somewhat redder and more healthy appearance. Attempt begun to reduce the hernia by strapping.

To-day the patient first shows an indurated ulcer at the prepuce, which has apparently existed about a week.

March 30.—Strapping has not been successful, but the wound is slowly and gradually closing and the testicle protrudes less. A

small knob on the surface of the testicle is cut off with scissors without any sensation.

April 24.—A roseola has appeared on the chest and belly. Specific treatment begun.

Meanwhile the wound has been progressing very slowly, but the cavity of the tunica vaginalis has wholly filled up and there is now a simple granulating surface as large as a 5-cent piece, with a small area of testicle in the center.

May 3.—Two attempts have been made to cover the testicle by sliding flaps over, but were unsuccessful on account of the stitches cutting through, although placed well back.

June 1.—Healing is now practically complete, having been finally brought about by approximating folds of the scrotum on either side of the granulating surface by means of collodion and straps of gauze, thereby relieving tension.

The most interesting question suggested by this case is that of etiology, and is discussed in the following report of Dr. Cotton, who had charge of the case and made a bacteriological investigation of it.

From the swab of February 24th there grew large numbers of colonies on all tubes, in pure culture (save for a single colony of *staphylococcus pyogenes aureus*, which may well have come from the skin). The bacterium in question was a micrococcus, perhaps a little larger than the *staphylococcus aureus*, appearing mainly in masses positive to the Gram stain. The cultures showed on:

Loeffler's serum: Colonies small, round, whitish; not characteristic; serum slowly liquefied, to a moderate extent only.

Agar (slant): A thin whitish layer of small, rather flat, colonies; moderately confluent; opalescent in transmitted light; in no way characteristic.

Sugar agar: Growth in depth less vigorous than near surface; surface growth as on agar.

Gelatin: Moderate, dull-whitish growth; at the sixth or seventh day liquefaction, progresses slowly, and after weeks reaches but slight extent; in form of a narrow cone, in the upper part only.

Bouillon: Clouding at twenty-four hours, which persists indefinitely; sediment moderate.

Peptone broth: No clouding; moderate white sediment; no indol produced.

Milk: Acid reaction; firm coagulum.

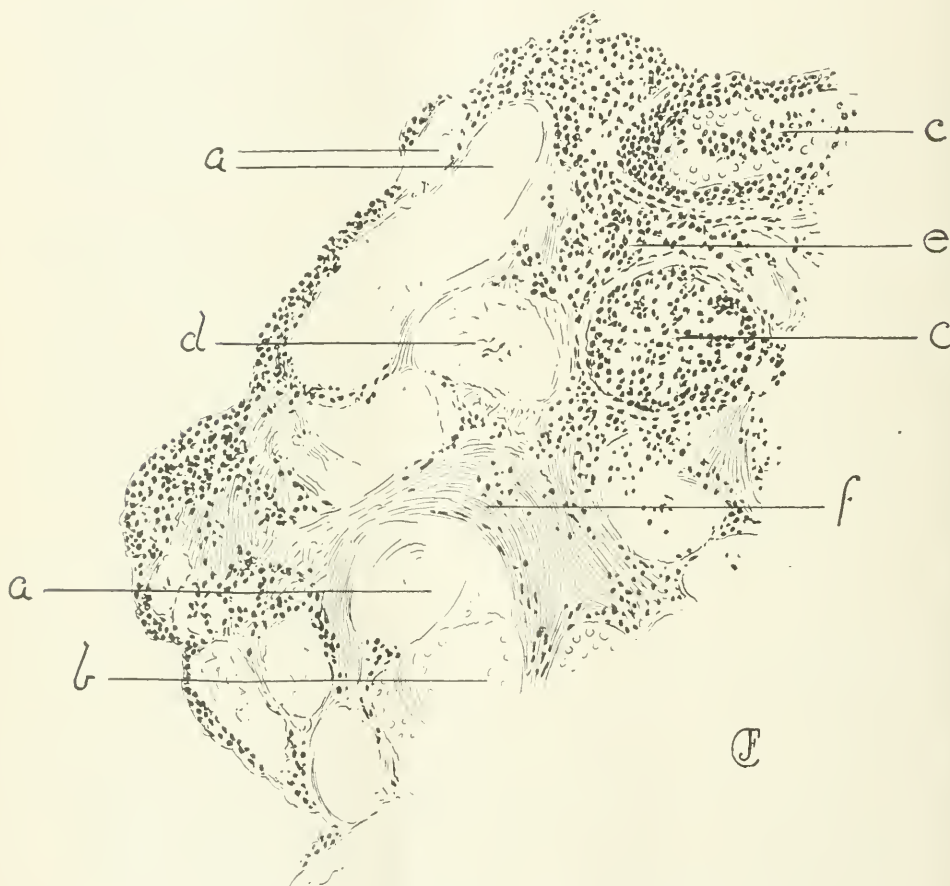
Potato: A thin, moist, grayish-white growth, not spreading; potato not discolored.

Intravenous injection into rabbit was without result.

Subcutaneous injection in a brown, intraperitoneal in a white, mouse, produced only a fleeting initial effect, apparently a toxemia from the relatively large amount used.

Cultures from the patient's urethra showed various cocci, but none exactly corresponding to this.

FIG. 9.



a, Tubules with necrotic epithelium. *b*, Unstained epithelial nuclei. *c*, Infiltrated tubules. *d*, Spermatozoa. *e*, Infiltrated stroma. *f*, Necrotic stroma.

This organism agrees in all but minor points with the staphylococcus pyogenes albus, of which it is probably a variety. I have not found a coccus with just such culture characteristics noted as among the inhabitants of the normal urethra, though the "micro-

coccus No. 3" of Petit and Wasserman is similar. I have, however, isolated from the pus of an old case of urethritis a coccus which agrees with this in all details; is not to be differentiated even in parallel cultures. The presence of a gleet in this case, the absence of any other apparent source of infection, make it at least highly probable that the coccus in question came from the urethra.

The bits of slough cut away February 26th (hardened in formalin, cut with the freezing microtome, stained in hematoxylin) showed testis tissue, in the main necrotic. The epithelium of the tubuli seminiferi was everywhere necrotic (save that fully formed spermatozoa in the lumen stained normally). (See Fig. 9.) A few tubules only were infiltrated with leucocytes, which lay among the necrotic epithelial cells, especially in the lumen (*c*). The stroma, in part necrotic, in part showing nuclei of the fibrous tissue, was densely infiltrated, but nowhere were there signs of syphilis, of tuberculosis, or of local abscess formation; the process was one of acute inflammation with necrosis simply. Tuberculosis may be safely excluded, and the later syphilitic infection shown by the patient, as well as the absence of the characteristic lesions in the section dispose of syphilis as a cause.

It would seem that an epididymitis and orchitis resulted from infection from an old urethritis, and that the process went on to coagulation—necrosis of part of the testis—to implication of the tunica albuginea, and so to rupture, without any abscess being formed. A similar process seems to take place in cases of apparently traumatic origin, as described by Lawrence (*Edinburgh Med. and Surg. Journal*, vol. iv, p. 257).

Whether the original infection of epididymis and testis was, or was not, due to the gonococcus, cannot be determined. There seems, however, every reason to assume that the acute process, which immediately led to the necrosis and to the hernia testis, was due to the micrococcus found in such numbers and in pure culture in the diseased part.

FREDERICK J. COTTON, M.D.

A CONTRIBUTION TO THE ETIOLOGY OF CONGENITAL
ICHTHYOSIS—REPORT OF CASE WITH ABSENCE OF
THYROID.¹

By JAMES M. WINFIELD, M.D.;

WITH MICROSCOPIC REPORT OF THE CONDITION OF
THE SKIN.

By J. M. VAN COTT, M.D.,

Brooklyn, N. Y.

THE scarcity of reports of ichthyosis congenita, with post-mortem and microscopic findings, have led me to present the following:

The family history, which was kindly furnished the writer by Dr. Robert A. Black, the family physician, is as follows:

Parents natives of the United States. (Father of German descent.) Father thirty and mother twenty-seven years old. Neither have had any severe illness. No history or signs of syphilis. The skin of each is perfectly normal and healthy, and, according to their statement, there is nothing to indicate the occurrence of ichthyosis in any of their ancestors; both paternal and maternal parents and grandparents are said to have had perfectly healthy skin.

• The mother has been pregnant seven times. The first and second children were born at term, and are still living and healthy. The third pregnancy resulted in miscarriage at the sixth month. Fourth, a boy, at full term, died when about a year old of some infantile disease. The fifth labor took place at about the eighth month; the result was the ichthyotic infant reported by Dr. Sherwell before this Association in 1894.

A year later she again became pregnant. Child was born at term, a perfectly formed boy, the skin normal in all respects. On account of some injury during instrumental delivery, the infant survived only a few minutes after birth. Six months later she became pregnant for the seventh time, and was delivered at term of another ichthyotic monster, the subject of this report.

During the first, second, third, fourth, and sixth pregnancies the mother's condition was excellent, she being neither nervous nor sick. The fifth, which resulted in the first ichthyotic infant, she was subjected to considerable anxiety, and at the sixth month received a severe nervous shock. When she became pregnant for the

¹ Read before the American Dermatological Association, May 5, 1897.

last time she immediately grew exceedingly nervous and worried lest she should become the mother of another deformed baby.

After delivery her mental state became so bad that Dr. Black thought best to separate the child from the mother. Accordingly he had it sent to the children's department of the Kings County Hospital, where it was first seen by the writer.

At delivery the infant weighed about four pounds. The bony

FIG. 10.



and muscular structure appeared to be perfectly formed; finger- and toe-nails absent; there was a slight ectropion of the right eye, although neither eye could be tightly closed; the lobe of the left ear was considerably smaller than the right; the scalp was covered with normal hair. The body was enveloped in what appeared to be a thick coating of vernix caseosa, which, on removal, left the skin red and shiny. If no lubricating protective was used the whole cutaneous surface soon became scaly and fissured.

When I first saw the case, four days after delivery, it appeared as follows: The whole body was covered with thick reddish-brown

epidermic plates which were larger and more marked over the extensor surfaces; some of them were from a sixteenth to a tenth of an inch in thickness, and a half to two inches in diameter; between the plates were fissures of varying depths; movement of the limbs produced cracks about the flexures of the joints, which extended deeply into the underlying tissues. Nursing was difficult on account of fissures about the angles of the mouth. The accompanying picture gives a fairly good idea of the appearance of the skin at this time.

The infant lived about two and a half weeks, dying from inanition and loss of temperature. Every effort was made to preserve its life, but in spite of constant inunction of mild borated and carbolated lanoline and cold cream, and careful attention to feeding, the child was too feeble to survive.

The autopsy was made about eight hours after death. The body was considerably emaciated, and covered with large, fatty, epidermic scales.

Internal organs—heart, lungs, liver, and spleen—normal. On examining the neck the thyroid gland was found to be absent. There was no sign or trace of its ever having existed. A number of slides were prepared from portions of the skin taken from the back, thighs, arms, and scalp. It gives me great pleasure to take this occasion to thank Drs. Van Cott and Murray for the pains which they have taken.

The following is Dr. Van Cott's report:

DR. JAMES M. WINFIELD,
Brooklyn, N. Y.

My Dear Doctor: Herewith I beg to report that I have made microscopic examinations of many microtome sections of the skin submitted by you to me from the baby presenting evidences of congenital ichthyosis.

The sections were subjected to the usual technical methods; portions were embedded in celloidine and cut upon a Throma microtome.

The horny layer of the skin is considerably thickened, the rete Malpighii appears fairly normal. The sweat and sebaceous follicles are present. Both the rete and subcutaneous areolar tissue present, in some of the sections, evidences of necrosis, with small, round-cell infiltration, and in certain areas the lymph spaces are occluded with occurrences resembling in every respect micrococci.

Those lymph spaces which are filled with these morphological

elements are more common in the neighborhood of the blood-vessels, both arterioles and venules.

It is a very remarkable fact that these occurrences are, apparently, confined to lymph-channels; except in a few areas of the subcutaneous areolar tissue, where they seem to be generally distributed.

At these points the tissues are in a state of coagulation necrosis, and give evidence of an acute degenerative process.

In those portions of the microscopic field where the lymph spaces alone contain these supposed micrococci, the histological findings are those of an inflammatory lesion, with very evident migration of white corpuscles and, presumably, phagocytosis.

The general impression conveyed by these microscopic findings is that of a bacterial infection, causing changes which fall short of a suppuration, but distinctly inflammatory in character.

Based upon these findings, my belief regarding the nature of this lesion is that there is at hand a dermatitis, the etiological factor of which must be regarded as a micrococcus, whose exact origin and nature are obscure.

It is perfectly well known that the fetus in utero may become infected with micro-organisms of various kinds, but the exact point of infection is often difficult to determine.

I would call attention to the fact that not all of the sections examined contained these appearances; which would lead to the supposition that their distribution is not general, but in localized areas.

It would be impossible to state the exact nature of these bacteria, if they be such, upon a mere microscopic examination; for the reason that there are many varieties of organisms which appear morphologically similar.

Whatever other changes of a finer nature may be present in this material (which will be easily summed up by the expert in dermatology rather than the pathologist), I am sure the above-described conditions must play an important, if not principal, rôle in the macroscopic changes in the skin.

Yours,

J. M. VAN COTT, JR.

The important etiological points are:

1. The absence of the thyroid.
2. The presence of micro-organisms in and about the lymph spaces.

3. How much the mother's mental and nervous disquietude during pregnancy had to do with the cutaneous deformity.

That the thyroid has some influence on the nutrition of the skin is an established fact, as is evidenced by the occurrence of various dermatoses when this body is atrophied or diseased; and, further, there are numerous recorded instances where the administration of thyroid extract has exerted a beneficial influence on skin affections where hyperkeratinization and thickening are prominent features.

Just what etiological bearing the absence of the thyroid has on the production of ichthyosis congenita and kindred diseases cannot be positively stated without further clinical and post-mortem proof; still, from the above facts, it is but fair to conclude that in this case, at least, the absence of this body had some marked effect on the nutrition of the skin, and the development of this cutaneous affection.

The occurrence of micro-organisms in the lymph spaces, at once brings up the question whether this and similar cases are types of true ichthyosis, or, as Dr. Van Cott puts it, a variety of dermatitis.

If these micro-organisms were the cause of this excessive plate formation it is possible that the term *ichthyosissebacé* is the correct one; for a bacterial irritation could easily produce a universal seborrhea.

It has been proven by bacteriologists that bouillon made from thyroids has an inhibitory action upon the growth of bacteria, consequently it is by no means rash to suppose that the normal thyroid has an inhibitory effect on various cutaneous bacteria. The absence of this body in this case could have rendered the subject peculiarly liable to such infection.

As Dr. Van Cott says, there is every reason to believe that the bacteria found in the specimens were the result of intra-uterine infection; for every precaution was taken during the life of the child to keep the skin in a perfectly aseptic condition, and immediately after death the body was put in a refrigerator and the specimens of skin were at once placed in a preserving-fluid, consequently the the growth of decomposition germs were prevented.

Regarding maternal impressions. It is not the purpose of this paper to attempt to say whether the mental and nervous shock had any bearing on the production of these monsters; still, it is a curious and interesting fact that three healthy and normal pregnancies were followed by perfectly formed children, while the two attended with worry, fright, and shock produced ichthyotic babies.

Society Transactions.

TWELFTH INTERNATIONAL CONGRESS OF MEDICINE.¹

MOSCOW, AUGUST 19-26, 1897.

SECTION IN SURGERY.

Treatment of Ischuria Following Hypertrophy of the Prostate.

—DR. BOTTINI of Pavia, in a paper on this subject, demonstrated his new method of dealing with these cases. His instrument resembles a lithotrite. The movable parts can be used as a galvanocautery for burning a groove through the prostate. The current is supplied by a specially made battery, and the strength of the current is entirely under the control of the operator. After the blades of the instrument have been inserted in the prostatic urethra, they may turned in the direction necessary to destroy that portion of the prostate which seems to offer the greatest obstruction to the passage of urine. The results of the method are excellent. Within a few days, sometimes hours, the patient urinates voluntarily. In ten days all catheterization can be stopped. The relief afforded, according to the author's claim, is complete and permanent. The instrument may be employed after local anesthesia by cocain. It obviates the dangers which have so far attached to all surgical attempts to re-establish the urethral canal through the prostate, especially doing away with the liability to hemorrhages. The cautery acts effectively in closing all blood-vessels. A current of ice-cold water flowing through the instrument effectually protects healthy tissue. The contraction of the resultant cicatrix is never sufficient, when the cauterization has been thorough, to bring back the old symptoms of prostatism. Surgeons from other lands, among them Freudenberg of Berlin, and Kümmel of Hamburg, have employed the instrument successfully, and the reports of their cases show that it is not in its inventor's hands alone that the instrument is effective.

Indications and Results of Lithotriety.—DR. ALBARRAN of Paris, reviewed the subject as it stands to-day. It was formerly said that there were two contraindications, youth and stones of extreme size, but these have disappeared before the advance of modern surgery. Scarcely ever is it necessary to do a cutting operation for stone. It is the rarest exception to find stone in a patient too young for the performance of lithotriety. The difficulty used to be the introduction of instruments strong enough to be depended on into the urethras of young male patients, but this has disappeared before the perfection of implements. As to the size of stone, nothing is too large for the lithotrite. He considers lithotriety one of the triumphs of modern surgery, in its pitch of perfection and universality of application. Instead of a serious operation with two or three weeks in bed in the

¹ By permission of Wm. Wood & Co., New York.

most favorable cases, there is one simple manipulation and the patient is able to move about in three days.

Ischuria from Prostatic Hypertrophy.—DR. FREUDENBERG of Berlin reviewed the various operations for difficult urination following hypertrophy. He regarded the Bottini method as the best and reported a number of successful cases, one in which, after everything possible had been done for the patient by the old methods, the prostatic urethra was enlarged by Bottini's electrocaustic method; he was able to urinate freely some hours afterward, and fourteen days after the operation all catheterization was given up.

DR. BOTTINI said that he had examined Dr. Freudenberg's modifications of his apparatus. They concerned especially the possibility of thoroughly asepticizing the instrument, and certain changes in the electrical connections and battery powers, and he considered them distinct improvements and recommended them to the profession.

DR. WATSON of Boston said that from his personal experience he did not think Bottini's apparatus applicable to all cases of prostatic hypertrophy. While it would be effective in the simpler cases of bar at the neck of the bladder, he hardly thought it would relieve the cases in which there was extreme prostatic hypertrophy. No amount of manipulative skill would enable one to direct the instrument so as always to come upon the offending prostatic hindrance.

DR. LAVISTA of Mexico did not consider the Bottini procedure applicable to the cases of extremely large prostate. He thought that the relief afforded in such cases would only be temporary.

Tumors of the Bladder.—DR. NITZE of Berlin read a paper on the intravesical removal of tumors of the bladder. He described a new cystoscope for the employment of a snare under full light in the cystic cavity. Only benign tumors can be removed. For malignant tumors a more radical operation must be employed when operation is indicated. Small tumors that have for years been causing serious constitutional trouble from hemorrhage can be easily removed, and even reasonably large tumors can be removed piecemeal. In the speaker's experience this method has given much better results than *sectio alta*.

DR. WATSON of Boston asked to be allowed to correct the impression made by the paper of Dr. Albarran, that cutting operations for stone were the favorite procedures for vesical calculus in America. He was glad to see that French surgeons had so thoroughly taken up the rapid method invented by Bigelow and were carrying it out with such perfection.

Elephantiasis of the Testicle.—DR. LE DENTU of Paris reported a case of elephantiasis of the testicle, hydrocele, lymphatic varicocele, and lymphangioma of the inguinal canal and of the pelvis due to the presence of *filaria sanguinis hominis*. The change of climate always arrests the progress of the filarial disease, he said, and he thought it probable that the use of electricity may be found to cause a retrograde process in the hypertrophied lymphatic tissues.

Pseudo-Cystitis.—DR. GUÉPIN of Paris, for himself and Dr. Grandcourt, read a paper on this subject. They held that there is a

series of diseases with bladder manifestations in which no pathological condition exists in the bladder. These have usually been diagnosed as cystitis, and it is only careful modern diagnosis that has differentiated them. The bladder symptoms in such cases are the result of nervous reflexes, principally from an affected posterior urethra, but they may also come from the anterior urethra, from the ureter, and even from the kidney. The result of the reflex nervous excitation brings on a congestion that aggravates the symptoms and makes the condition still more simulative of true cystitis. The diagnosis is often extremely difficult, and depends finally on careful local examination. It is to be remembered that in cases of false cystitis the symptoms are always aggravated by intravesical medication.

Absorption by the Mucous Membrane of the Bladder.—DR. GEROTA of Bucharest showed by a series of microscopic plates that, while there was imbibition on the part of the mucous lining of the bladder, there was no real active absorption. Coloring matters were found to have penetrated between the cells, but they were not taken up by the lymphatics. Poisons, such as strychnin, might thus gradually and very slowly find their way into general circulation, but they were not really absorbed.

Spontaneous Fracture of Vesical Calculi.—DR. SEVEREANO of Bucharest reported a case of spontaneous fracture of a large calculus. He discussed the theories of the cause of the fracture, rejected the idea that it was due to active excessive contraction of the bladder-walls, but thought it was much more probably due to the formation of carbonic acid within the calculous masses.

Prostatectomy.—DR. DESNOS of Paris read a paper on this subject. He regarded the hypogastric route the preferable one, as the surgeon has to grope less in the dark, can more readily diagnose the exact condition that causes the urinary difficulties, and is better able to judge what the indications for operation really are. In twenty-three prostatectomies he had successful results in thirteen, the patients recovering almost completely their urinary potency; in four cases there was distinct improvement in the urinary symptoms. In the midst of the new inventions for the relief of prostatism now so frequent, he believed that the old traditional procedures still had their place and that improved technic with modern methods made them often the operation of choice.

Metastases of Endotheliomata.—DR. SCRIBA of Tokio read a paper "On the Clinical Diagnosis of Endotheliomata and Their Special Manner of Giving Metastases." He said that these tumors, arising from the endothelium of the smallest vessels, are much more frequent all over the body than is generally supposed. They have been taken for carcinomata most frequently, from their tendency to metastasis in the lymph glands, but sometimes also for sarcomata. Clinically they may be differentiated by their metastases differing from sarcomata, in that they give metastases to the lymph glands, and from cancer because their metastases are not so hard, grow more rapidly, and are not painful.

Permanganate of Potassium in Lupus.—DR. KACHANOVSKY of

St. Petersburg read a paper on this subject. He employs powdered permanganate of potassium. The powder, freshly prepared from dehydrated dried crystals, is applied in a layer, three to five millimeters in thickness, over the whole surface of the lupus and the suspected portions of the surrounding tissues. In case of deeper ulcerations with undermined edges, the powder is applied after curetting two or three times in order to level the uneven surface. In all cases a layer of medicated cotton is put over it to keep the powder in place and absorb the secretions and eliminated material. In most cases a single application of the powder suffices. He has employed the powder now in more than thirty cases since 1878, and always with complete success.

Hot-Air Treatment of Lupus.—DR. E. HOLLANDER of Berlin had first tried the local application of steam for lupus but without result, as the patients were unable to stand a temperature sufficiently high to affect the diseased tissues. Then he tried hot air. His apparatus consists of a Bunsen burner, on the top of which is mounted a coil with a tube passing through it. To one end of the tube is attached an air-pressure bulb for driving a current of air through the coil; the other end is left open. A current of air heated to 300° C., may be driven through the coil and directed very exactly by the patient himself, so that it affects only the diseased parts. The mode of action of the process is, according to the author, as follows: The intensely hot air produces an active contraction of the vessels of the skin and of the diseased tissues. They become blanched and bloodless; after two or three days the blood returns to the supporting framework of connective tissue, but not to the diseased granulation tissue. Cicatrization sets in and a radical cure results.

DR. SCHULZ of Duisburg had had very good results from extirpation of the diseased part followed by Thiersch's skin transplantation. The success of the process depends on the thorough removal of the diseased tissue. If any of this is left, reinfection of the whole surface will often follow and absolutely prevent the skin grafts from taking.

THE NEW YORK DERMATOLOGICAL SOCIETY.

TWO HUNDRED AND SIXTY-SECOND MEETING, HELD ON TUESDAY
EVENING, MAY 25, 1897.

DR. J. A. FORDYCE, *President, in the Chair.*

A Case for Diagnosis.—DR. C. W. ALLEN presented an old gentleman, a physician, whom he had once before shown to the Society, about eighteen months ago. At that time the man had a lesion on the lip which some of the members regarded as syphilitic, while others thought it was cancerous in its nature. At the same time he had some papillomatous lesions on the inside of the mouth about which there was some difference of opinion. The specific nature of the lesions was disproved by the non-effect of internal specific treatment. Under applications of the acid nitrate of mercury the buccal

lesions readily healed, and there had been no recurrence of the lesion on the lip, which got well under caustic potash burnings. Recently a lesion of leucoplasia, resembling an ordinary smoker's patch, had appeared upon the lower lip.

DR. DANIEL LEWIS said he thought the lesion on the lip would eventuate in cancer. At present it illustrated a condition which he was in the habit of designating as "pre-cancerous."

A Case of X-ray Dermatitis.—Presented by DR. S. LUSTGARTEN.

The patient was a woman, fifty-four years of age, well built and healthy in appearance. Her abdomen was exposed to the Roentgen rays on January 3, 1897, and also a fortnight previously, each day twice, each exposure lasting from fifteen to thirty minutes. The tube was placed at a distance of eleven inches.

About ten days after the last exposure an ulcer formed on an inflamed area, which was accompanied by intense attacks of pain of a burning and lacinating character; these attacks occurred several times during the day, and often lasted the entire night, rendering sleep impossible. Reddening and slight swelling of the edges preceded the pain; these symptoms extend in an irregular manner over the surrounding skin, and disappear with the subsidence of the pain.

The condition has remained practically unchanged in spite of various therapeutic measures extending over a period of four months. When he first saw the patient, on May 5th, he found, directly under the navel, an irregularly outlined slough, yellowish, dry, leathery, firmly attached to the underlying tissue, and to the edges. The horizontal diameter of the lesion was three inches; the vertical, a little over two inches.

A wet dressing with liquor Burrowi was prescribed, which gave great relief but did not produce any marked change in the appearance of the lesion after two-weeks' use.

DR. FRANK P. FOSTER said the statement had been made by a number of gentlemen who had used the X-rays extensively that these skin lesions did not occur if the exposures were properly made. Dr. H. G. Klotz suggested permanent, or as far as possible, protracted baths as a method of treatment.

DR. LUSTGARTEN said that in this case marked relief was afforded by the wet dressing, while other applications, such as salves containing cocain, etc., had been of no use whatsoever. The speaker said he considered this condition as absolutely unique. It is dissimilar to any form of gangrene with which we are acquainted. Another case of this affection had recently come under his observation. The patient was a woman who had some disease of the finger-nails. Her son, who was an electrician, conceived the idea of removing the old nails and accelerating the growth of new ones by means of the X-rays. The hands were exposed for an hour daily for several days. The exposures gave rise to an intense inflammation of the skin of the fingers, extreme pain, with loss of the nails, and followed several weeks later by ankylosis of the joints of the end phalanges.

A Case of X-ray Dermatitis.—Presented by DR. A. R. ROBINSON.

The patient was a man who had been exposed to the Roentgen rays with the object of finding a bullet which was supposed to be located in the chest. On May 1st he was exposed for $4\frac{1}{2}$ minutes, followed by a photograph with fourteen minutes exposure. On the 6th of May there was some inflammatory redness of the skin on the man's back, which gradually grew more pronounced and at the present time there is some necrosis of the most superficial tissues of the affected area. The eruption shows at the peripheral part many hard, dark-colored papules, many of them perforated by hairs. The eruption commenced over a small area at first and gradually extending at the periphery, now occupies an area about six inches in diameter.

DR. E. B. BRONSON, who had seen Dr. Robinson's patient about ten days ago, said the course of the lesion in this instance was very similar to that in his own case, which he had shown at the previous meeting. (*Jour. of Cutan. and Genito-Urinary Diseases*, October, 1897.)

DR. J. A. FORDYCE thought the only rational treatment was to remove the slough with the knife.

A Case of Pemphigoid Eruption.—Presented by DR. E. B. BRONSON.

The patient was a child that recently had scarlet fever. The disease had followed its usual course, but toward the completion of the desquamating stage an eruption of a papular character appeared on the arms below the elbows, and on the legs below the knees. The attending physician prescribed a salve under which their eruption disappeared. Shortly afterward, however, blisters made their appearance on various portions of the body. They have come and gone ever since.

The patient had first come under Dr. Bronson's observation a few days ago. At that time, over the extremities and face, there were a number of large vesicopustules, some of them the size of an almond, while others were as small as a split pea. Almost all of them were purulent in character. The speaker said he was under the impression that the eruption was originally the result of an infection from pus organisms, and probably at first was an impetigo contagiosa.

DRS. JACKSON and KLOTZ thought the case was one of impetigo contagiosa.

DR. FOX said he thought the case was one of impetigo contagiosa bearing some resemblance to pemphigus. The point of distinction was the irregularity in the distribution of the individual lesions on the extremities. In pemphigus of the extremities the lesions are apt to appear in serpiginous form.

DR. LUSTGARTEN regarded Dr. Bronson's patient as an example of those rare cases of pemphigus eruption following an acute septic infection. He referred to a case coming under his observation wherein the eruption developed after croupous pneumonia and persisted for several months. The speaker said he did not think we should stretch the clinical entity of impetigo contagiosa too far. A

certain number of the cases of impetigo contagiosa following vaccination are probably examples of this form of pemphigus.

DR. ELLIOT regarded the case as one of impetigo contagiosa. He referred to a similar case which had come under his observation at Bellevue some years ago. In that instance the lesions developed after vaccination; they readily disappeared upon the application of an occlusive dressing, but immediately recurred when the skin was uncovered and the patient permitted to scratch. Dr. Elliot said he did not understand why such lesions should be regarded of hæmatogenous origin rather than due to external causes. He referred to a case shown by Dr. Allen about a year ago which soon got well under external treatment.

DR. LUSTGARTEN said he did not think these cases were as readily cured as Dr. Elliot's remarks seemed to indicate. The lesions might persist for a year or two. Impetigo contagiosa, on the other hand is self-limited, and usually of short duration. He thought there was in the character of the lesions a marked clinical difference between these two conditions.

DR. BRONSON, in closing the discussion, said it was perfectly evident that pus organisms had a great deal to do with the disease. Under germicidal treatment marked improvement had occurred. The speaker said that while he agreed that the disease was largely the result of pus infection, he thought there was another element present which depended on some primary impairment of nutrition. The reaction in this case was much more severe than is usually seen in cases of simple contagious impetigo. Pemphigus, as Erasmus Wilson has said, is due to defective innervation, in which the slightest amount of inflammatory hyperemia is attended with separation of the epidermis and the formation of bullæ. The speaker thought that his case was essentially pemphigoid in character, though of course not a case of true pemphigus.

A Case for Diagnosis.—Presented by DR. GEORGE T. ELLIOT.

The patient was a man with peculiar lesions on the backs of the hands, and the extensor surfaces of the forearms, with a few isolated lesions on the rest of the body. There was also a general follicular hypertrophy, all the follicles being very prominent and distinct. The patient states that his skin affection first made its appearance about three years ago. It was worse in winter, gradually improving in the summer, but never entirely disappearing. There were no subjective symptoms with the exception of occasional slight itching. The eruption had first appeared on the buttocks and had left there pigmented scars. Similar scars were also observed on the backs of the hands, and over the extensor surface of the forearms.

DR. C. W. ALLEN reported a similar case which had been under his observation. The patient was a young man in whom the eruption first appeared four years ago; since then he has had three similar attacks, all of them occurring in the winter. In these attacks the erythematous stage was very brief, and was followed by a papular stage. The papules surrounded the follicles and a central tenacious, deeply implanted, or core-like crust, formed, which, on disappear-

ing, left a pitted cicatrix. The patient's hands were studded with these cicatrices, and there were a few scattered lesions on other parts of the body, especially the feet; sometimes there was suppurative inflammation. In his case, as in that of Dr. Elliot, the symptoms improved very much during the warm weather. The only constitutional trouble that could be made out was a gouty tendency, with thickened areas upon some of the tendons. Dr. Allen said he had never seen any description of these cases in literature, and in his own case had not been able to make a positive diagnosis.

DR. ELLIOT thought there was some resemblance between his case and the keratosis follicularis of Hans von Hebra. The microscope shows nothing but horny follicular plugs, with considerable inflammation in the corium. The speaker said he thought the case was one of keratosis follicularis. There were no evidences of contagion. Dr. Elliot, in reply to a question, said that while we know very little about the etiology of these cases, the treatment is very simple. They rapidly improve under greasy applications, combined with a little salicylic acid.

A Case for Diagnosis.—Presented by DR. S. SHERWELL for Dr. Henry H. Morton.

The patient was a man, fifty-seven years old, a native of Germany. His family history was good. The patient had always enjoyed good health; there was no history of syphilis. About fourteen years ago he first noticed a lesion on the left buttock, which was treated by Kussmaul, who cauterized it. The lesion, however, never entirely disappeared; it gave rise to no subjective symptoms until about three years ago, when it began to annoy him by burning and itching, and it also increased in size. At that time, in order to exclude syphilis, he was given a number of hypodermic injections of mercury. Later on, with the idea that the case was one of lupus, the lesion was again cauterized. There is now some extension of patch to right buttock.

DRS. ALLEN and CUTLER thought the case one of lupus vulgaris. Dr. Jackson also regarded the case as one of lupus vulgaris. He had seen the patient some time ago, when the opposite buttock was covered with a similar lesion, which had since disappeared. At that time he thought that it bore a resemblance to a syphilide.

A Case of Alopecia Areata Combined with Seborrheal Eczema.—Presented by DR. FOX.

The case was similar to the one he presented at a previous meeting. The patient was a woman forty-three years old. The patch was located on the left side of the head in front of the ear. It began two months ago as a small, perfectly smooth bald spot that appeared suddenly. At first it was the size of a 10-cent piece, but it has slowly grown so as to form a patch some two inches in diameter. It presents two peculiar features. One is that upon it there are several red patches such as are seen in seborrhea. The other is that there are a number of broken-off hairs in the patch, and in the hair surrounding the patch. There are some similar red patches on neighboring parts of the scalp.

DR. BULKLEY said he saw no reason why seborrheal eczema should not exist coincident with alopecia areata. He had observed such cases, and regarded both as present in this instance. He did not think that the smooth baldness was caused by the seborrheic disease, but only a coincidence.

DR. BRONSON thought that the coexistence of these two conditions was exceptional. He did not think there was any pathological connection between the two affections.

DR. ELLIOT said he saw no reason why a man should not have alopecia areata and seborrheic eczema at the same time. In the previous case shown by Dr. Fox the eczema had produced an alopecia which was not a true alopecia areata.

DR. FOX, in closing, said that this condition was very rare in his experience. Among many cases of alopecia areata he had only observed two instances where the bald patch was the seat of a seborrheal eczema.

A Case of Lupus Erythematosus, with Lesions on the Mucous Membranes of the Mouth.—Presented by DR. S. LUSTGARTEN.

The patient was a male, twenty years old; a salesman, who immigrated to this country from Russia eight years ago. His parents are both alive and well, as are also two sisters. One brother and three sisters died in childhood. The patient states that when he was eight years old he had a skin affection located on the scalp and face, which was characterized by thick crusts. Two years later he had typhoid fever which lasted several weeks. The present affection of the skin was first noticed about four years ago, appearing symmetrically upon both zygomatic bones and gradually spreading until it reached its present limits. The patient's heart and lungs are normal; his appetite is fair; he has no fever. He states that he has lost considerable weight within the past year. On the face are two large, irregularly shaped, symmetric patches, bright-red in color, surrounded by several smaller spots of the same character, from the size of a pin's head to that of a bean. The larger patches show irregular areas of healthy skin within their boundaries, partly elevated yellowish-brown patches, with an uneven, scarred surface. The lesions appear slightly raised, of purple-red color, not disappearing entirely upon pressure, surrounded by a congested, erythematous halo, with uneven, flat edges. In the center of the lesions are firmly adherent thin scales in the older spots, upon depressed, cicatricial, partly atrophied bases. There are a few follicular scars forward the nose, the result of old lesions. There is only one small patch of recent date on the hairy scalp. Upon the lips (especially the upper) there are a few isolated and one confluent plaque, thereby thickening the lips. The scales upon the lips are shred-like. There are several isolated plaques upon the vermillion border of the lips and on the mucous surface of the mouth which do not inconvenience the patient, who is an inveterate cigarette-smoker. The conjunctiva of the lower eyelids, and the ciliary border, appear red and congested. The follicular orifices upon the face seem slightly enlarged and filled

with thickened sebaceous retentions. The case corresponds to Besnier's type *erythémateux-folliculaire*.

DR. KLOTZ called attention to the considerable amount of scar formation, which, unless it was the result of treatment, would indicate that this one of those cases which bear so close a resemblance to a lupus vulgaris, that it is often difficult to diagnose correctly.

A Case of Generalized Scleroderma.—Presented by DR. BULKLEY.

The patient was a girl, eleven years of age; a native of Connecticut. She was fairly well-developed, and had enjoyed good health up to about one year ago, when her mother noticed erythematous blotches, more or less urticarial in appearance, scattered over the skin, principally on the upper portion of the body. At that time no hardness of the skin was noticed. Suddenly, about two or three months ago, the entire skin seemed to harden. At present there is a generalized scleroderma, which is apparently progressing quite rapidly. The face has a peculiar drawn, staring appearance, owing to the immobility of the skin. The urticaria-like blotches were still visible over the back.

DR. MORROW said he had seen two cases of localized scleroderma, both of which improve very rapidly under the influence of thyroid extract. In one of the cases, where there was a history of rheumatism, he gave, in addition to the thyroid, potassium iodid, and afterward salicylate of soda.

DR. FOX said he should hesitate in pronouncing Dr. Bulkley's case one of generalized scleroderma. Although the skin is bound down in certain areas, there does not seem to be any subcutaneous hardening of the tissue, and there is no particular change in the texture of the skin. The prognosis in a case of this character Dr. Fox thought was good. He suggested a diet composed largely of milk and eggs, combined with the use of massage and galvanism.

DR. FORDYCE said Dr. Zolnowski had informed him that he had succeeded in curing a case of scleroderma by means of hot baths and massage.

DR. LUSTGARTEN said he regarded massage as the best therapeutic measure, which is sometimes followed by remarkable improvement. It should be combined with hot baths and applications of salicylic acid ointment.

DR. BULKLEY said a peculiar feature of this case was the appearance of the erythematous lesions, which showed a disturbance of the nutrition of the skin and which had preceded the hardening for about a year. He had never seen this recorded in connection with any other case of generalized scleroderma. The child had received one Turkish bath, and since then the skin had become somewhat softer. She is also being massaged daily and is receiving inunctions of lanolin. Dr. Bulkley said that the hardening of the tissues and the hide-bound condition of the skin of the arms and other localities are precisely similar to what has been observed in other cases of generalized scleroderma during the early stages.

DR. BRONSON said that about a year ago he showed a patient from

the City Hospital who was suffering from generalized scleroderma. In that case the treatment consisted of massage, hot baths, andunctions, but the improvement was very slow. The tissues over the face became softened, but in the other affected areas the hardness remained.

DR. FORDYCE showed a section of a pigmented tumor which he had recently removed from the arm of a man thirty-seven years of age. The tumor was congenital and the patient stated that each summer it became ulcerated and discharged a blackish fluid. It was warty in appearance and firmly embedded. The microscope showed that the growth was a pigmented mole which thus far evinced no malignant tendency.

DR. ELLIOT said that his patient with hydradenitis, whom he had shown at several of the recent meetings of the Society, was improving without any treatment. The speaker exhibited a microscopic specimen showing how the sweat-follicles were involved.

Selections.

GENITO-URINARY DISEASES.

The Treatment of Chronic Gonorrhea. DR. LEOPOLD CASPER
(reprint from *Berliner Klin. Wochenschr.*, 1897, No. 15).

Although this paper contains nothing really new, yet it gives such a concise array of facts that it is well worth a careful study. In spite of the multiplicity of new drugs set forth as having gonococidal properties, these cases remain as difficult and tedious to treat as ever, and still depend for their successful treatment upon the careful study of each case, the locating of the pathological process, and the choice of the proper method for that particular case. To adhere to one mode of treatment, or merely to squirt into the urethra this or that germicide is to court failure. It would be absurd to call attention to the uselessness of merely injecting the anterior urethra when the real focus of disease is in the posterior urethra, as it is in the majority of chronic cases, were it not still done every day by men who should know better.

The author gives to Janet the credit of being the first to bring some system out of the chaos of gonorrheal therapeutics, and bases his treatment largely upon it. He distinguishes between gonorrheal urethritis and the urethritis due apparently to other microbes, *i. e.*: those cases only are gonorrhea which contain the gonococcus. Besides this, we must also recognize aseptic catarrhs, the secretion being free from all micro-organisms, and consisting only of round and epithelial cells. Aseptic catarrh may arise from trauma, mechanical, or chemical, or it may remain after a gonorrhea has been cured. The point is that while one antiseptic drug may fit the gonorrheal process, and then the urethritis bacterica, we should not think of applying a germicide, but some astringent to the catarrh.

Frequently a fresh outbreak of an old gonorrhea is looked upon as a new attack, and treated as such, the patient using a simple injection. The discharge is quickly stopped and the patient looked upon as cured, when, as a matter of fact, the process is merely quiescent, ready to break forth again at a favorable opportunity.

It is of importance to recognize whether the process is superficial or deep-seated and infiltrating the deeper layers, whether diffuse or circumscribed, and, finally, whether there are any concealed foci in any of the neighboring glands which open upon or near the urethra, especially those of the prostate or Cowper's glands, as it is these very cases which may go for months, or even years, without giving any sign, only to break out and cause an apparently fresh attack at some favorable opportunity.

Thus we must note the cause, situation, duration, the kind of process, the extent, the micro-organisms, and the presence of juxta-urethral foci before applying our therapeutics.

The indications, as laid down by Janet, are: (1) Removal of the gonococci; (2) removal of other pathogenic organisms, either at the same time or after the removal of the gonococci; (3) to cause the disappearance of the catarrh; (4) heal circumscribed foci; (5) heal the infiltrations; (6) destroy all peri-, para-, or juxta-urethral foci.

For the performance of the first indication the author recommends thallin, or permanganate of potassium or nitrate of silver, either by irrigation of both anterior and posterior urethra by Janet's method, or by catheter and hand syringe. For the second indication, sublimate seems to be of use; for the third, persisting after all germs have been removed, nitrate of silver, sulphate of zinc, and permanganate of zinc are of use. The strengths of solutions used by him are those ordinarily recommended by majority of writers; potassium permanganate, from 1-5000 to 1-1000, exceptionally 1-500; silver nitrate, 1-5000 to 1-500; sublimate, 1-20,000 to 1-6000; zinc sulphate and permanganate, 1-5000 to 1-500.

These irrigations act better in the diffuse forms, while for the circumscribed forms, where the urethra for the most part is sound and affected only in isolated points, as the lacunæ and glands (a glandular or periglandular urethritis), or granular patches. These being the rarer forms of the disease, the urethroscope is found to be of use. The affected spots being touched by more concentrated solutions, as silver nitrate, up to 20 per cent.; copper sulphate, 10 per cent.; or zinc chlorid, up to 1 per cent.; and, in very rare cases, even by the galvanocautery.

Where, however, these patches are deeper-seated, forming infiltrations, and there is a proliferation and emigration process of white cells going on in the submucosa, a condition whose eventual outcome is stricture formation, such infiltrations may harbor gonococci. The superficial secretion appears merely as an aseptic catarrh, no gonococci being found until, suddenly, under favoring conditions, these germs again appear in the discharge. The logical treatment is by the passage of sounds, combined with irrigation,

or medicated sounds, etc.; or the combined dilatation and irrigation method of Lohnstein; or, in those cases in which the meatus is narrow and does not admit of enlargement, dilation by the Oberländer dilator is of use.

It is in these cases that superficial bridges of mucous membrane (bridles) may quickly form, being especially adapted to harbor and protect nests of gonococci, which cannot be dislodged until they are divided.

It is only when these infiltrations are so advanced that they can be discovered by olive-tipped bougies that sounds are indicated, though they are also of use in expressing the contents of diseased follicles. This is apt to be the case when the disease is of several months' standing. The diagnosis of this condition may be made in the earlier stages by the urethroscope, the mucous surface showing pale and dull, with loss of brilliancy of the light reflex, loss of the normal striations, or an appearance of inelasticity to the funnel-shaped bit of mucous membrane brought into view by the instrument. The earlier stages of these infiltrations may be rendered worse by sounds, and here the instillations with the Guyon or Ultzmann syringe of silver nitrate are of use. The pain caused by these methods is best allayed by previous use of cocain or eucain.

Finally, of great importance is the search for, and removal of, the foci in the peri-, para-, and juxta-urethral glands. Cowper's glands, and especially the prostatic glands, must be examined. By massage of the urethra over the region of Cowper's glands, a sound being previously introduced into the bladder, the contents of these may be expressed. The author lays great stress upon the value of massage of the prostate where the prostatic glands are affected, advising even daily massage of the prostate; and claims success in rebellious cases by massage of this organ, even where there is no objective proof of the existence of a prostatitis. He omits, however, all mention of possible seminal vesiculitis in some of these cases.

Then the question arises, When should treatment cease? The ideal, of course, is where every trace of secretion is gone; but this is by no means to be attained in all cases, and there are many cases which always show a colorless drop, or filament, of mucous, and epithelial cells, with a few round cells, and yet are never dangerous, provided that irritation of any kind cannot cause them to show a return of gonococci. The walls of the urethra have lost some elasticity; the glands of the urethra secrete abnormally or do not hold their secretions, though this need not be of any moment. Overtreatment is to be avoided, or these cases readily become neurasthenic.

The author regards examination of the urine and urethra, after the patient has held his urine for a period of five or six hours during the day, as of more value than the examination before the morning urination. He admits that there are some few cases still, in spite of every treatment, which apparently can never be rid of their gonococci, but these are far fewer than formerly.

Results of Surgical Intervention in Vesical Tumors. PROFESSOR ALBARRAN. (*Ann. d. Mal. d. Org. Gén.-Urin*, 1897, p. 785).

This is a study of the gravity of operation, percentage of recurrence, and length of survival in epithelial neoplasms, benign and malignant.

The figures published by Albarran in 1892 comprising operations practised from 1888 to 1892 show a mortality of 6 per cent. to 7 per cent. in operations on benign tumors, and of 45 per cent. in those on malignant tumors. In 1894, Clado collected the operations published from 1892 to 1894, and found a mortality almost analogous to the preceding. These figures, however, do not necessarily argue against an advance in operative technic, for though the mortality may remain the same, the operations of this second period were more extensive, therefore more serious in point of view of immediate results.

The results from the point of view of recurrence show a more marked difference. In the report of 1892 there was 19 per cent. of recurrence in benign tumors; in 1894, 14 per cent. In the case of malignant tumors in 1892, recurrence was 60 per cent., in 1894 only 31 per cent. This marked difference in favor of malignant tumors may be in part explained by the fact that during this time partial resection of the bladder-wall has been more largely employed. This however, is not sufficient to explain this wide difference.

As regards time of survival, in 1892 Albarran found only three cases of benign tumor operated on longer than four years in whom there was no return.

In cases of true epitheliomas, he found three patients who had lived one, two, and three years respectively, after operation. Clado gives nothing on this point.

Statistics, however, in these cases are of but little value as methods of classification vary. These cases differ greatly in themselves though histologically they are the same, or they differ in the degree of evolution and in the operation employed; then too, though agreeing histologically they will be placed under different categories, the same class of tumor being denoted epithelioma by one, papilloma by another. These though of the same nature, from their situation they differ in gravity of operation and probability of recurrence. For example, in a flat tumor, parietal in nature, even though small of dimensions we must fear "concealed" infiltration and also glandular infection. When, on the other hand the epithelioma, though voluminous, develops in the interior of the bladder and is pedunculated, the propagation into the bladder-wall is slow of growth, and glandular infection a negligible quantity. As a matter of fact these latter are in reality old benign tumors transformed into epithelioma, while the parietal tumors are cancerous from the start.

Albarran has operated on 29 tumors, 6 papillomas, 22 epitheliomata, and 1 sarcoma. Mortality 6 deaths, 20 per cent. The six cases of papilloma all survived, and no recurrence in the cases followed up. Manner of operation was removal of tumors with the surrounding

mucous membrane, the point of implantation was sutured and bladder closed. When tumors had an implantation sufficiently extensive, a resection of entire thickness of bladder-wall was made, taking up sufficient healthy bladder-wall between the tumor and incision. In this way the suprapubic cut for papilloma seems safe and without gravity, though acute anemia of the patient from severe hemorrhages should be overcome, and sufficient time allowed the patient to regain his strength before operation.

In these cases we should not only extirpate freely, but the interior surface of the bladder should be carefully examined and every suspicious verrucosity destroyed.

A. cites two cases operated for papilloma, one in 1891, on a man aged fifty-two years. Seat of tumor behind right ureter; the other, operated same year, had a papilloma situated in the *bas-fond*. The first, after six years, and the second at the end of sixteen months, had no return.

The operative results in malignant tumors are far from being as brilliant. Out of 23 malignant cases there were six deaths. Four of these cases had a palliative operation only. In two there was extensive excision of the bladder-wall practised. One of the latter had a large tumor surrounding the lower portion of the right ureter, and almost the entire vesical mucous membrane presented villousities, so that total extirpation of the bladder was performed. Patient died thirty-six hours after the operation, probably of shock. The other case survived twelve days and presented symptoms of iodoform poisoning. In this case symphyseotomy was done and extensive removal of bladder-wall. The autopsy revealed peri-encephalitis and double pyelonephritis. These two cases then had extensive operations combined with a bad general condition. Still out of four symphyseotomies and extensive removal of bladder-wall, there was only one death, and out of seven cases of total extirpation of bladder, five survived. A. does not believe that symphyseotomy adds to danger of operation. In the malignant cases which survived, symphyseotomy was practised three times, and resection of lower end of ureter, with suture of ureter into bladder wound was done twice.

Of great importance in these cases is the choice of time for operation. The patient must not be too much exhausted by extensive hemorrhages, but steps should be taken to build him up before attempting extensive operation, aided by large injections of serum.

The ultimate results of extirpation of malignant tumors remain to be considered. A. has been able to follow seven cases for a length of time sufficient to be of interest.

One, a Mexican, forty-eight years, presented an anterior wall toward the right, a sessile epithelioma the size of a two-franc piece. A complete resection of the bladder-wall was made, passing wide of the tumor. News at the end of three years and four months showed no recurrence.

Another, of Fontainebleau, had a very large tumor, the bladder being distended by an enormous growth, and having severe hemorrhages. The pedicle covered an area of two centimeters in diam-

eter. Operation in 1894; tumor removed, base cauterized, hemorrhage stopped by cat-gut sutures. The growth was epithelioma. In July, 1895, eleven months after operation patient returned, had had hematuria for three months. Suprapubic cystotomy showed another tumor, larger than a nut, in a new position, the site of the former tumor showing no recurrence. This second tumor was a papilloma, twenty-two months after the second operation, three years after the first there is no return of trouble. The cystoscope showed a healthy bladder.

Another observation was that of a patient operated upon in 1892. The cystoscope showed a sessile tumor as large as a mandarin in the posterior-wall of the bladder touching the right ureter.

Complete extirpation of tumor with entire thickness of bladder-wall, bladder was closed by seven points of suture, the tumor was epithelioma. There is no return after five years, the bladder being perfectly healthy.

In June, 1894, a patient, thirty-six years of age, presented himself with symptoms of bladder-growth. A sessile tumor two centimeters in diameter was found on the anterolateral wall near the vesical neck. Operation: symphyseotomy was performed on account of site, and resection of bladder-wall performed; bladder closed completely, and symphysis closed by silver sutures. The tumor was a sarcoma. Six months after operation there was no return; not seen since.

Operations upon three other patients were not so favorable. One, a young man, in 1890, operated upon for a pedunculated tumor situated outside the left ureter. Recurred in one year; patient waited two years and five months after first operation. Then symphysiotomy, with resection of bladder-wall measuring four by six centimeters. Patient then well for three years when hematuria recurred and a parietal tumor found in anterior bladder-wall which was excised through a transverse cut. This tumor recurred within a year. Patient desired further operation, but only a palliative operation could be performed. Death the next year.

The second, in 1892, had a sessile tumor behind the interureteral line; complete resection; six months after operation he died of cerebellar tumor.

The third presented a neoplasm surrounding the mouth of right ureter. Complete resection of bladder-wall, and three centimeters of lower end of ureter. The ureter was sutured into bladder-wound. This patient continued well for two years but through a friend A. heard that two months later he was suffering from bladder trouble.

CUTANEOUS DISEASES.

IN CHARGE OF DR. B. LAPOWSKI.

Pemphigus Vulgaris and Vegetans, with Special Consideration of the Formation of Bullæ and Condition of the Elastic Tissue. F. LUTHLEN (*Arch. f. Der. u. Syph.*, xl, p. 37).

Two cases of pemphigus vulgaris and one of pemphigus vegetans from Kaposi's clinic supplied the material for the author's investiga-

tions. Clinically, they do not vary from the classical description of pemphigus—but the histological examination of the bullæ taken from the patients *in vivo* is of great interest. They show the seat of the blebs is not between the stratum granulosum and stratum lucidum as usually accepted, but between the epidermis and corium; that the whole layer of rete is uplifted from the papillæ, leaving only here and there some interpapillary projections which serve later as a rudiment for repair of the epidermic cover of the papillæ when the skin is restored to its healthy condition.

The rete itself does not participate to any great extent in the process; it is quite unchanged, but the elastic fibers, which serve as a connecting link between the rete and cutis propria undergo a notable change, entirely disappearing where the exsudative process is at its height, and becoming thin, short, and narrow where the exsudation is not so marked. These changes of the elastic tissue are due to the power of the exsudation-fluid to soften and macerate the elastic tissue (Kromayer). The primary cause of this exsudation is still enveloped in mystery.

As to pemphigus vegetans, histological research confirmed the clinical observations of Kaposi that the affection is not a disease *sui generis*.

Anatomy and Pathogenesis of Pemphigus Blebs. E. KROMAYER (*Derm. Zeitschrift*, vol. iv, p. 474).

Basing his statements upon thorough histological examination of numerous bleb-covers and of five bullæ *in toto*, the author gives a very ingenious explanation of the nature of pemphigus. Histologically the upper portion of the bleb is formed by epidermis, which is uplifted entire from the cutis. The epithelium of the rete is not changed, the protoplasm and epithelial nuclei can be stained easily. The most important alterations are seen in the cutis, where the elastic and especially the collagenous tissues are edematous. The serous contents of the blebs are sometimes endowed with the property of macerating tissue, and that endowment does not depend upon the quantity but quality of the exsudation, as we see large blebs, filled with serous fluid, which does not possess the power, and very small blebs in which that quality is present in a high degree. As the exsudation is chiefly derived from the vessels, the power to raise the rete by maceration of the links between the cutis and epidermis must be derived from some other source than the vessels, and in his opinion it is due to chemical change in the tissue cells.

Examining a bleb we will very often see upon the lower surface of the raised epidermis appendages consisting of sweat-ducts, hair-follicles, and lanugo hairs in bleb-contents. As the cutis, sweat-glands, and hair-follicles are provided with separate vessels, the macerating power of the fluid cannot lie in the exsudation product of the vessels but in the nerves, the only tissue-link between the cutis, follicles, and sweat-glands. Under the influence of the nerves the chemical composition of the tissues is changed, producing an edema of the collagenous fibers and evolving by irritation an inflammatory

process even around old pemphigus blebs—the periphery being of a tropho- and angioneurotic character. Kromayer is of the opinion that it is not the elastic fibers, but the collagenous tissue, which being in close connection with the epidermis, is mostly changed by the macerating contents of the pemphigus blebs.

Dermatitis Herpetiformis. HALLOPEAU and LAFITTE (*Annals de Derm. et de Syph.*, t. vii, p. 1442) confirm the value of eosinophilia occurring simultaneously in the blood and bleb-serum as a diagnostic sign in this disease. Two cases were examined, and the cells and granules found in number, while in one case of pemphigus foliaceus, only a few were discovered, at a second examination, in the blood alone. DANLOS (*idem*, t. viii, p. 288) states that the cells occurred in abnormal quantity in two of his cases.

HEHIR (*Indian Med. Gazette*, 1897, April 1) records a series of cases. In the bleb-serum he found a small diplococcus, enclosed in a thin capsule. They were found in the leucocytes, singly, in pairs, or groups. They do not form zoöglea, and cilia were demonstrated by various stains. The author recommends ichthyol externally, arsenic and pilocarpin internally.—*Edinburgh Med. Journ.*, Oct. 1897.

Histology and Character of Xanthoma Tuberosum Multiplex.

GEYER (*Arch. f. Der. u. Syph.*, 1897, p. 67).

Our present knowledge of xanthoma is chiefly due to the investigations of Chambard, whose opinion that the two forms of xanthomata, planum and tuberosum, are identical both clinically and anatomically, is questioned by Touton and denied by Unna, especially as to their anatomical structure. The clinical and histological examination of the following case gave the author an opportunity to form an opinion in regard to the clinical and histological features of the two varieties of xanthoma. The patient, thirty-three years of age, noticed several tubercles on the buttocks shortly after an attack of pain in the lumbar and gluteal regions. Two months later pain manifested itself in the back, upper extremities, and neck, and shortly after the gradual diminution of the pain very small tubercles appeared on the aforesaid portions. Upon examination the neck, back, and extensor surfaces of the extremities were found to be covered with characteristic xanthoma tubercles. Internal organs were in good condition. The examination of the urine revealed one-half per cent. of albumin, no sugar, a small number of white corpuscles, with scattered epithelial bladder-cells, and some granular casts. During the prolonged period of the disease the composition of the urine remained in close relationship with the evolution or involution of the xanthoma: an improvement of the condition of the kidneys was followed by an absorption and fading of the tubercles; an exacerbation of the affection of the kidneys resulted in an appearance of new tubercles.

This clinical association suggested to the author the possibility of an etiological connection between xanthoma and the renal dis-

turbance, and he is of the opinion that this suggestion is more than supported by his histological examinations.

According to the author, the lymphatic vessels lying at the apex of the dermal papillæ, are the starting points in the formation of xanthoma. Through these lymphatic vessels are carried on the nutrition changes between the corium and rete. Any change in the chemical composition of the lymph—be it lack of nourishing quality or excess in toxic substances—will have an effect upon the endothelium, the chief factor in the exchange. A concentric proliferation of the endothelial lymphatic cells, raising the rete Malpighii, will produce a small tubercle. While circulation in the central portion of this tubercle is gradually stopped, the peripheral cells are not disturbed in their growth. The absence of an intermediate layer of cutis between the tubercle and epidermis explains the characteristic straw-color of even the smallest xanthoma tubercle. Geyer concludes that xanthoma is not a local affection, but is due to some general disturbance of the system, and accordingly cannot be placed among the tumors. The process is neither a proliferation due to irritation, nor a fatty degeneration, as the fatty metamorphosis takes place in active and living cells. Xanthoma tuberosum may be transformed into xanthoma planum, but then the characteristic fat of the tubercles disappears. Anatomically and clinically the case described is quite different from xanthoma of the eyelids.

A Case of Xanthoma Tuberosum Diabeticum. C. TOEFFER (*Arch. f. Derm u. Syph.*, xl, 1897, p. 3).

In a man of forty-two years of age a xanthoma eruption appeared upon his body and lasted, spreading gradually, for ten years. His urine contained five per cent. of sugar, pentose absent, but clinically no symptoms of diabetes were present. The amount of uric acid was not increased, but the solubility of the uric acid diminished, a condition which we find in so-called uric-acid diathesis. The patient was restricted in the use of nourishment containing albumin and advised to put himself on a vegetable diet. The involution of the xanthoma eruption was very rapid, the sugar gradually disappearing. After a sojourn in Carlsbad, sugar entirely disappeared, reappearing several months later, while the involution of the xanthoma tumors continued.

Histologically, the xanthoma tumors consist of fibrous bundles, which emanate from the connective tissue of the skin. The yellow, fat globules lie embedded in the cells of the fibrous cords. The tumors are not of inflammatory origin.

He is of the opinion that under the name of xanthoma various tumors, very different in their histological structure, are included, hence the chaos in classification of this group.

Pentosuria and Xanthoma Diabeticorum. T. COLOMBINI (*Mon. f. prak. Derm.*, vol. xxiv, 1897).

This case represents two interesting points: It is, first, the first reported case of a skin affection combined with pentosuria; second,

a unique case of a skin eruption associated with diabetes, where another variety than grape-sugar (glucose) was found.

A man of fifty years was affected with a characteristic xanthoma diabeticorum. When the author, after repeated attempts, failed to find glucose in the patient's urine, he directed his investigations toward determining the presence of some other variety of sugar, as levulose, inosite, lactose, or pentose. Using Falkowski's and Yastrowitz's method, and verifying by Tollen's test, he found 0.352 per cent. of pentose. The patient was put under a milk and meat diet (free from pentose) and arsenic internally. In four months the eruption disappeared. Repeated examinations of his urine did not reveal any pentose after disappearance of the eruption. The presence of pentose in small quantity in the urine may be due to the kind of food used by the subject, as the vegetable kingdom (cherries, prunes) is rich in substances producing pentose. But Falkowski denies the connection between pathological pentosuria and the nature of the diet. Hammarsten thinks that pentosuria is due to an abnormal formation and increased destruction of the nucleoprotein corpuscles in the pancreas.

Dermatitis Medicamentosa. A. J. HALL (*Clin. Jour.*, vol. x, No. 19) reports some interesting cases of drug rashes. The eruption in the first case was due to potassium iodid. Instead of the usual pustular or nodular lesions, there appeared bright scarlet, irregular patches of erythema of large size, which, here and there, especially on the lobes of the ears, showed vesiculation. Arsenic, in the second case, caused a pustular outbreak on the back, legs, arms, and hands. Salicylate of sodium was believed to have produced a mixed rash of erythema and nodular lesions. It disappeared on leaving off the drug, but iodid, previously administered, may have been responsible for the nodules. In a case of extensive burns, boracic acid, in ointment, powder, and lint, was responsible for an intoxication which resulted fatally. A scarlatiniform erythema, punctiform or running into irregular patches, appeared on the lad's body after four days of the application. The palms and soles were intensely red. The erythema was marked at the edge of the burns. The tongue was glazed, the temperature 102° F. The boy died in four days, semi-delirious, the temperature reduced, and the conjunctivæ much inflamed. In a second, similar case, also with fatal ending, boracic acid was found in the urine. The last case reported was a folliculitis, resulting from the use of oil of cade.

Arsenic intoxication, according to MÉNEAU (*Annals de Derm. et de Syph.*, t. viii, No. 4, 1897) may be acute, subacute, or chronic. The first may result from contact, as in the case of workmen, or in local application. The cases are quite rare, and are usually pustular, with occasional gangrenous accidents. Intoxications by ingestion are more common, and of varied character. The eruption may be erythematous, ecchymotic, papular, erysipelalous, pustular, bullous. Gangrene has been reported a number of times. Intense pru-

ritus is a not uncommon accompaniment. Subacute poisoning differs from the preceding only in the smallness of the dosage; the effects are identical. Generalized, exfoliating dermatitis occurred in one epidemic in 268 persons. Gourbeyre has reported a case of urticaria following use of Fowler's solution. In chronic intoxication there may be diffuse or localized pigmentations, vesicular eruptions, ulcerations following the latter, and papillomatous growths, resembling cancer. The poisoning is accidental, professional, or medicamentous. Keratosis of the palms deserves particular mention. According to Hutchinson, it has three stages: dryness with itching, production of tiny indurations, termination in epithelioma. The use of arsenical mineral waters, internally or in baths, is also productive of medicamentous dermatitis. The author closes with an apropos arraignment of the common, indiscriminate use of the drug. It should be reserved for cases where there is a "stagnation of the formative element of the rete cells, and when that element is depressed by a chronic inflammatory process." Its action is stimulating. A full bibliography is appended.

COULON and VERNY (*Bull. Méd. du Nord*, 1896, p. 301) report a case of antipyrin eruption following, after eight hours, the ingestion of a gram. Large patches, irregular in size and distribution, appeared over the body, principally on the neck, ears, lids, as well as on the trunk, limbs, and oral mucous membrane. Three days later vesiculation appeared. On a later repetition of the dose, after four minutes, itching became intense, and a new outbreak, similar to the first, appeared.

ORO (*Giorn. delle Mal. Ven. e delle Pelle*, 1896, p. 285) observed an eruption from copaiba, given for acute gonorrhea. The rash was erythematous, slightly pruriginous, and predominated on the trunk, forearms, and hands. Histological examination showed inflammatory infiltration of the corium.

PFaff (*Jour. Exp. Med.*, March, 1897) records some interesting experiments on the active principle of rhus toxicodendron. It is not toxicodendric acid, described by Maisch, although he did find acetic acid, but an oil which, on test upon a colleague, was found to have, even in small quantity, intensely irritant effect. The latent period varies from nineteen hours to nine days, the average being five days. The oil, called toxicodendrol, is not volatile, so that actual contact is necessary. It produces nephritis and fatty degeneration of the kidneys like cantharides. It is soluble in alcohol and is precipitated by lead acetate, so that the exposed parts should be washed, as soon as possible, in an alcoholic solution of the lead salt.

The Therapeutic Use of Aiol in Dermatological Practice. T. S.

LÖBLOWITZ (*Arch. f. Der. u. Syph.*, xxxviii, 2, p. 231).

Unpleasant Effects following the Use of Aiol. M. GOLDFARB (*Monat. f. prak. Derm.*, vol. xxv, p. 228).

Löblowitz, availing himself of the property of aiol to set free iodine when brought in contact with secretions or pus, applied in Pro-

fessor Pick's clinic airol to diseased surfaces of several varieties; to primary syphilitic lesions, exulcerating papules, gummatous ulcers, inguinal suppurating lymphadenitis, varicose ulcers of the leg, combustion, lupus, and internally in two cases of tertiary syphilis, and one case of rhinoscleroma. Internally, airol was administered in 1- to 3-grain doses daily, without any inconvenience to the patient. Iodin could be found in the urine five days after the last ingestion of the drug. The therapeutic effect was very satisfactory. Before applying airol externally Löblowitz cleaned the sore with ether and with an antiseptic; then he covered it with a thin layer of airol, followed by a mercurial plaster or airol gauze. The application was renewed twice daily. In the case of chancres the floor was clean in two to three days, the secretion greatly diminished, the sores had a dry, shiny aspect for a couple of days, when healthy granulations appeared. In other sores the astringent property of airol was more manifested than its antiseptic power. The author never saw any irritation produced by airol upon the healthy skin; only a slight burning sensation is felt when used upon ulcerations. Being odorless and cheap, airol may be used with advantage when an astringent action is desirable, but it cannot replace iodoform when we aim at an energetic antiseptic action.

Not so fortunate in his experience with airol was Goldfarb. He used airol in powder form in two cases of soft chancre; covered them with a thin layer of cotton, and drew the prepuce over it. Early the next morning, after a sleepless night due to severe pain, the two patients reappeared with large bullæ filled with serous fluid such as are seen in burns of the second degree.

Caustics and Massage in Psoriasis. ACHILLE BREDÀ (*Giorn. Ital. delle Mal. Ven. e delle Pelle*, 1897, iii, p. 366).

The action of caustics as applied by patients themselves attracted the author's notice. The first used nitric acid with the result of causing permanent disappearance of the lesions on the arm so treated at the expense of equally permanent scar-formation. A second used an alcoholic solution of corrosive sublimate (1-5) after scraping off the crusts. No relapse occurred in the patches. Bredà used, after this experience, nitrate of silver and acetic acid. Both caused pain, and the former keloid in addition. Somewhat better results followed massage in an obstinate case, the skin regaining a healthy appearance and itching disappearing.

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Original Communications.

SOME CASES OF FEIGNED ERUPTIONS.¹

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THE simulation of various diseases has been resorted to in every age, and by all classes of society. When the purpose is to avoid conscription, work, or duty, the simulator is usually a male; when to excite sympathy and interest, or to obtain notoriety, a female. In some cases the malingering or simulation is apparently motiveless. Of course, mendicants from time immemorial have simulated diseases which are peculiarly abhorrent to the passer-by, such as sloughing ulcers, running sores, scabs, contractures, etc, but this is for the purpose of provoking pity and charity. In some cases, since the introduction of railways and modern machinery, persons simulate nervous symptoms and spinal injuries for the sake of obtaining compensation, and this, when obtained, results in a permanent cure. A remarkable case of simulation of disease has lately been exposed in France. A man simulated locomotor ataxia so perfectly that the great Charcot and many other prominent Parisian physicians were deceived. He went from hospital to hospital, and, finally, was sent to Notre Dame de Lourdes, where he was miraculously cured, and was kept as an example of what our Lady of Lourdes could do, to the mortification of many members of the medical profession. However, he was detected committing a theft of money from his spiritual doctors and they

¹ Read before the Twenty-first Annual Meeting of the American Dermatological Association.

had him arrested. He then confessed everything, including the fact that he had been shamming, and that the miracle of cure was performed by himself. Mania is another form of disease which is often simulated, and is sometimes most difficult to detect.

The fact that skin diseases are often feigned is well recognized, and in some cases the deception is so clever that the fraud may for a long time go undiscovered, especially if the patient falls into the hands of medical men who have no sense of humor, for such are easily imposed upon.

The common forms of eruption which are simulated are the erythematous, bullous, and vesicular, for these are easily produced by irritants, such as Spanish fly, mustard, acids, etc., and repeated applications of such unguents, as pointed out by the late Dr. Hilton Fagge, give rise to appearances which differ from those we are accustomed to see as the result of the use of the same substance as a local remedial agent.

Heat and friction with the fingers are often made use of to produce lesions of the skin. According to the late Mr. Startin, tartar-emetic ointment has been used successfully to simulate lupus.

Local gangrene, which has been called erythema gangrenosum, spontaneous circumscribed gangrene, etc., according to the late Dr. Tilbury Fox, is always the result of artificial production. He says repeated applications of nitric acid or Spanish fly will cause gangrene, or, first, the application of Spanish fly, and on top of this nitric acid. It is well known to surgeons that the heat produced by a rubber bottle filled with hot water will produce gangrene of the skin in patients whilst unconscious from ether.

One of the cases reported below is an example of the spontaneous gangrene, and, taking all things into consideration, although no absolute proof was forthcoming, the case is doubtless one of feigned eruption.

It goes without saying, that it is most important to have a knowledge of real disease in order to detect a simulated one. The fact that most of these feigned eruptions differ from any known skin disease, both as to their situation, symmetry, and common appearance, together with the looks, history, and general conduct of the patient, must lead any intelligent and observing practitioner to suspect the fraud. That there is no known cause for the deception, or that no benefit can accrue to the simulator, goes for nothing. To excite interest and draw attention to herself is a sufficient inducement to a hysterical woman. I am inclined to believe that, on

account of the large audience, cases are seen more frequently in the public clinics than in private practice.

In the two cases of large bullous eruptions of the cheeks, I omitted to test the acidity of the fluid, and so lost the opportunity of deciding whether or no the lesions were produced by an acid. Mr. Startin (*Brit. Med. Jour.*, January 8th, 1870) relates a case where he detected a fraud by getting an acid reaction of the bullous contents with litmus paper.

CASE I. *Gangrenous Patches of Skin on the Arms.*—Amelia B., aet. 30, a servant employed in the Montreal General Hospital, was brought to me by the lady superintendent in July, 1890, and was said to be suffering from a peculiar eruption of the skin, which had been coming out for the previous week or ten days. The eruption was on the back of both hands and forearms, and consisted of a number of circular patches about the size of a 10-cent piece. Some of the patches were quite dry, hard, and gangrenous, and of an almost black color; others were shiny, and of a dead yellowish color, and quite insensitive; and some, again, were merely red and inflamed. Around the edges of each patch was an inflammatory areola, and a slight line of demarcation was already beginning to form. In some of the patches a number of concentric rings could be made out very distinctly, looking as if they were produced by a metal disk. I at once said that the eruption had been produced artificially, but the patient indignantly denied it, and the people in authority over her scouted the idea. I said no more patches would appear if she were carefully watched and a bandage put over her hands and arms. She was admitted into one of the wards, and the hands and arms covered, first with absorbent cotton, then with a dextrine bandage. At the end of a week the bandages were removed and no fresh spots were seen; some of the old ones had disappeared, and in others the sloughy skin had come away, leaving superficial ulcers, which soon healed. The lesion was evidently produced by the bottom or cover of some metal box, or other similar article, heated to a high temperature. The object of the trick I could never discover, unless it was to get off her work. Apparently she was not in any way hysterical.

CASE II.—Elizabeth B., aet. 44, a sturdy, thick-set woman, with a stolid appearance, was employed as cook on a large dairy farm near the city of Montreal. Came to my skin clinic July 4, 1894, complaining of troublesome blisters on the cheeks.

She said that, it being the haying season, she was pressed against her will into the field work, and all the previous day was loading

hay. The weather being very hot, she sweated a good deal, and frequently wiped her face with her apron. She said there was milkweed and poison-ivy in the hay, and to this she attributed the condition of her face. Her face was quite well when she went to bed, but on awaking in the morning it was all red and swollen, her eyes

FIG. 1.



were closed, and she had numbers of large blisters on her cheeks. The blisters rapidly increased and coalesced. (Fig. 1.)

On examining her I found that on each cheek were several huge blisters, extending from the lower border of the orbit to the inferior maxilla; there was also a patch of large vesicles on her forehead,

but the eyelids, eyebrows, and hairy parts of scalp had escaped, as also had the lips. Around the blisters the skin was red and inflamed. The edges of the eruption were quite sharply defined. A few days later, having abstained from haymaking in the interval, she returned almost well, a slight reddening of cheeks and forehead being all that remained of the original eruption. From the situation of the eruption, its sharp definition, and the general appearance, I came to the conclusion that it was artificially produced by cantharides, carbolic, acetic, or other acid, the object being to avoid further work in the field. From what she told me she seemed to dislike exceedingly going into the fields, because she thought it was not her proper work, and I have no doubt at all that some blistering agent was applied to produce the eruption. The eruption resembled no known disease of the skin.

CASE III.—Laura R., aet. 28, living at home, came to the hospital October 15, 1893, complaining of eruption on the chest.

She was a nervous woman, who had most of the hysterical stigmata, such as occipital pain, insensitive throat, and no corneal reflex, of considerable intelligence. She said that some two years before croton oil had been applied to her chest for some lung trouble, and that ever since a croton-oil rash came out at intervals, in fact, that it never went away entirely. On examination a typical croton-oil rash was seen covering her chest, breasts, and between them. She seemed to take quite an interest in showing the eruption to the class of students, and was not at all abashed in having her breasts uncovered. A placebo was prescribed, and I did not see her again for a month. She came back November 15th, with each cheek covered with a huge blister, half full of fluid; on right side the blister was quite baggy. They were very similar in appearance to those seen in the case of Elizabeth B. The blister did not invade the eyelids, mouth, or nose. There was considerable inflammation about the blister, and the eyelids were swollen and red. It looked exactly as if the cheeks had been painted with some blistering fluid, or had been burned. The croton-oil rash on the chest had almost disappeared, and she said it always did this when the blisters came out on her cheeks. When the blisters first came out the rash began to disappear on the chest, until it went quite away. The blistering rash on the face usually, she said, lasted ten days, and afterward she had no symptoms of any kind for perhaps a month. She returned again in a week, and there was only a slight redness where the blisters had been, and there was no rash on her chest. I told her to come back when she felt the blisters coming out on her cheeks. She did so in a month. Her cheeks

were flaming red, hot, and somewhat swollen, but as yet there were no blisters. I wanted her to remain in the hospital for observation, but she declined, promising, however, to come back in a day or two.

This she did, and her cheeks were as the first time, each covered with a huge blister. She now tells me that sometimes she has no blisters for six months. The croton-oil rash at this time was almost imperceptible. She frequently returned to the clinic to show herself, the croton-oil rash being the favorite exhibition with which she

FIG. 2.



was pleased to entertain the students. No doubt her object was to excite sympathy and interest, and to be looked upon as an exceptional case. The girl was distinctly hysterical, both in her appearance and actions.

CASE IV.—Eliza C., aet., 24, waitress, was admitted into the Montreal General Hospital October 13, 1896, for gangrenous patches on the left foot and leg. The following is the history bearing on the case:

Four years ago she had a severe attack of typhoid fever. After convalescence had been established some time, she felt a severe pain in the left groin. This was followed by rapid swelling of the whole leg, which in two days reached its maximum, and afterwards gradually subsided. There was always present a sharp pain, which sometimes prevented sleep. When the swelling had disappeared from the leg there was a tendency to edema of the foot if she stood about much. A year later ulcers broke out on the dorsum and inner side of left foot. She said they looked very much like those she had now, and that there was dead skin which had to be separated. She was treated for these sores in hospital, and the scars are plainly visible. In January, 1894, the sloughing of skin came again in the same foot and leg. The skin now turned black, but when it came away did not leave such deep scars as formerly. Last March, 1896, she had another attack of the same kind of sores, for which she was treated in this hospital, and was discharged, cured, after a few weeks, the ulcers left by the sloughs being healed by skin-grafting. Since discharged from hospital she has been quite well, except that the left foot was inclined to swell. A week ago foot and leg became inflamed and swollen, and a day later the skin became discolored in patches, and around the dark discoloration there was considerable inflammation. On entering the hospital the following note was made of her condition:

"Patient is an intelligent, healthy looking, well-nourished girl, with a bright complexion; pulse and temperature quite normal. Several scars are seen about the calf of leg and dorsum of foot, and one bluish mark above the knee, which, she said, was due to a bullet wound, from the accidental discharge of a revolver. The exit of the bullet is also seen in the outer side of leg, above the tuberosity of the tibia. Over the foot and ankle are several white scars, due to former ulcers. On dorsum and inner side of the left foot, reaching as far as the great toe, are four well-defined necrotic patches of skin of various sizes, from half an inch to five inches in length. The largest patch, five inches long and two broad, is on the dorsum of the foot; the smallest a little below, and the two remaining ones on the inner side. There are a few very small patches in various parts of dorsum and outer side of foot. The foot is swollen, but the inflammatory reaction is very slight. All the patches are quite black, and around each is beginning a line of demarcation." (Fig. 2.)

There is nothing abnormal about the girl, and hysterical stigmata are not present. In a month the sloughs had separated, leav-

ing deep ulcers, and these were slow to heal; in fact, it took two months more before they were healed. Some of my colleagues contended that this was a case of localized gangrene following typhoid fever, and due to some interference with nutrition; in fact, an arteritis. This view was held by Dr. Armstrong, under whose care she last was, and who has kindly allowed me to make use of the case. Seeing that the toes and extreme periphery of feet were not involved, we could hardly put it down to Raynaud's disease. There was no blueness of extremities, nor any appearance of circulatory disturbance. Again the sloughing patches followed the course of no one nerve, the portions of skin involved being supplied by the external and internal saphenous and musculocutaneous nerves. Again, I found out that the girl was an inveterate cigarette smoker, and was addicted to liquor. The lesions might have been produced by the burning end of the cigarette. How the eschars were produced was a puzzle, but I have seen exactly similar ones produced by burns and scalds, and the application of too hot rubber water bottles to patients coming out of ether. As to the object of the girl, it might have been to excite sympathy, and also to get back to the hospital, where the peculiarity of her case excited the interest of the numerous students who had work to do in the ward, and she also was the subject of an occasional bedside clinic by the surgeon in charge. These, with the idle life, are quite sufficient inducements to such a girl to mutilate herself in this way. Perhaps the original foot lesion was due to accident, and the subsequent ones to design. The recurrence of the attack was a suspicious circumstance to my mind, as were also the intervals of complete good health between the periods of ulceration. I have since learned that before leaving the hospital this girl came running out of the ward kitchen, where at that time there was no fire, with her clothes on fire. The fire was promptly put out by the nurses. This circumstance I consider as confirmatory evidence, and makes me suspect still more strongly the artificial character of the gangrene. I am acquainted with no disease in a young, healthy person to which this corresponds.

152 Mansfield st.

A CASE OF SPONTANEOUS GANGRENE OF THE SKIN.

BY WILLIAM THOMAS CORLETT, M.D., L.R.C.P., Lond.,

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MISS E. B., aged fifteen, of German parentage, was brought to me April 8, 1897, by her attending physician, Dr. J. A. Tripp of Nottingham, for a peculiar eruption on the right foot and leg. She was a large, robust-looking girl, had always lived in the country and, aside from her cutaneous ailment, seemed in perfect health. The mother said the patient had first menstruated at the age of thirteen. After a few months the catamenia became irreg-

FIG. 3.



ular, occurring every fortnight. This condition lasted until about a year ago. Otherwise her health had always been good. Her father was an undersized man, had never been strong, and about a year ago became suddenly faint while working, fell, and upon regaining consciousness found his left side was partially paralyzed. A brother and sister of the patient died when young from diarrhea and diphtheria respectively. Aside from this there was nothing in the family history bearing on the case.

The present condition was attributed to having had her cheek rubbed with a leaf by a young man while picking grapes in August

last. No attention was given this until the following day when two spots resembling burns appeared on her left cheek. This corresponded in position to the part rubbed with the leaf. There was considerable edema of the cheek, two blisters formed, and on the third day another was added to the group. It was tender when touched, otherwise not painful. The lesions went through the changes of a severe burn and lasted about three weeks. On September 27th, ten days after the lesions healed, the patient complained of severe abdominal pain and was confined to bed until October 4th, at which time the attending physician believing it to be hysteria commanded her to arise, which she did and made no further complaint.

The patient again consulted her physician December 27, 1896, for a lesion on the dorsal surface of the middle finger on the left hand, resembling those previously mentioned on the cheek. It began at the side of the nail, with a slight formation of pus and extended upward to the hand. As there was marked edema, and thinking it might be a felon it was freely incised, but no pus was found in the deeper parts. Complete resolution took place within a fortnight. On March 21, 1897, while bathing, the little toe-nail of the right foot broke off close to the skin, which was followed by edema and sloughing of the integument in all respects similar to that of the finger. This was also opened by a free incision, but no pus was found. In about three days this developed to a silver-dollar-sized lesion involving the base of the little toe and extending backward with a circular well-defined margin. At first it was reddish, resembling a slight burn, on the second day it became whiter in the center, and later developed a deep, sloughing margin. Soon a reddish irregular silver-dollar-sized lesion appeared on the outer margin of the dorsum of the right foot, over the base of the metatarsal bones. A few days later the eruption continuing to spread, she was brought to me by Dr. Tripp, who confirmed the history and evolution of the disease as given. There were two roundish, dime-sized superficial scars (Fig. 3) of the cheek corresponding to the first lesions supposed to have arisen from contact with a grape leaf. One suggested the appearance of an incipient keloid. On the finger the destruction of tissue was less marked; the line of incision was clearly seen. Fig. 4 shows the eruption in its various stages. The nail of the little toe had fallen off, at the base of the toe there was a dark, yellow area, depressed in the center, with the epidermis shriveled and hanging in shreds. This was surrounded by deep sloughing which in places extended through the skin. There was some edema on the dorsum of the foot. The lesion at the base of the metatarsal

bones presented the most unique appearance. It consisted of a dead, yellow, apparently depressed central area, surrounded by a bluish or purplish margin beyond which there was a prominent blister-wall surrounding the whole lesion. Above the ankle the same process was going on, although it had not completely passed the erythematous stage when the photograph was taken. On the calf of the leg there was a well defined reddish lesion, which looked as if the part had come in contact with a piece of hot metal, although no evidence could be obtained favoring this view.

FIG. 4.



The patient complained of no special pain when quiet, although it was difficult to walk on account of the extensive destruction of the skin. The sensibility of the skin of the leg seemed slightly erratic, although no definite abnormality could be made out. The urine was examined by Dr. Tripp with the following result: passed in twenty-four hours sixty-five ounces, specific gravity 1026, no albumin or sugar being present. Previous qualitative tests had been made. I visited the patient, who was unable to leave the house, April 20th, when the eruption had extended upward to the reddish line shown in Fig. 4. The lesions at the base of the little toe were healing rapidly, while the

skin was completely detached from the lesion at the base of the metatarsal bones, leaving a deep granulating surface. On the leg the lesions did not present the sunken appearance previously noticed, but the dead, yellowish color was present, and through the shriveled and elevated epidermis a hemorrhagic area could be made out. The inner aspect of the foot and leg were not involved. Nine days later, April 29th, I was told by the attending physician that the lesions were healing kindly and no new ones had appeared.

The case is of especial interest because the disease is given little or no attention by most American authors, and in England there is a tendency to regard such eruptions as instances of malingering. Under "Dermatitis Gangrenosa," 3d edition, p. 346, Duhring, cites a case reported by Leloir and Dejerne,¹ which occurred in a young girl of nervous temperament. It consisted of superficial gangrene on the cheeks, followed by linear scars and "keloid." During three years similar patches occurred on the trunk and arms. They began by a pricking sensation, slight redness, and diminution of sensibility; within nine hours whitish patches formed, followed by sphacelation, ulceration, and scarring. In this case new patches appeared every fifteen days. Neumann, Kalb, Doutrelepont, Kaposi, and others have each reported a case occurring in young girls in which various regions of the skin have been affected in like manner. In some neither anemia nor hysteria was present.²

In this connection may be mentioned the numerous instances of local erythema and blistering of the skin by suggestion. Thus, in 1840 Pryalmini and Presalmins with so-called magnetized strips of paper produced the effect of cantharides. Bjornstrom demonstrated that erythema, blistering, and bloody transudation, even to the formation of a wound, might be produced by the same means. Numerous other instances of a like nature might be given by Charcot, Richet, Kraft-Ebing, Bernstein, and Facachon, men of international reputation, who are known as trained and scrupulous observers.³

¹ *Le Prog. Méd.*, 1881, p. 385.

² "Mal. de la Peau," Kaposi, with notes by Besnier and Doyon, 1891, p. 488.

³ *Revue de l'Hypnotisme*, June, 1890, p. 361.

NEPHRECTOMY FOR CYSTIC ADENOMA IN A PREGNANT WOMAN; A SECOND REPORT.

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THE nephrectomy here reported was described immediately after the operation.¹ It is a case of sufficient importance to warrant a record of the conditions existing after a lapse of three years. The facts are briefly as follows:

The patient, a woman nineteen years old, was first seen in January, 1891, because of a continuous dragging pain which she suffered in the left side of the abdomen, and because of a movable bunch which she felt in the region of the pain. An examination found a slight fulness in the left lumbar region. This fulness corresponded to a mass within the abdomen about the size of a normal kidney, having a smooth surface, a rather dense, elastic feel, and moving slightly downward with inspiration. There was no frequency of micturition. The urinary examination showed a sp. gr. of 1022, a slight trace of albumin, and a considerable sediment with hyaline and granular casts. A diagnosis of a movable left kidney was made. The patient used a truss for several months with considerable relief to the pain in the abdomen.

In March, 1894, the patient now being married, it was found, upon examination, that in addition to the presence of the signs of pregnancy of about three months, the tumor in the left lumbar region had increased to the size of three fists, and was growing rather rapidly. The swelling was aspirated and the fluid withdrawn was examined by Dr. Wood of the Harvard Medical School.

The result of this examination is recorded in the previous account of the case: Color, blood-red; reaction, slightly alkaline; amount of sediment, much; urea, a very slight trace; albumin, a large amount (more than one per cent.); bile pigment, a large quantity present; sediment, chiefly normal blood-globules, partly in rouleaux; numerous fatty and brown granular cells, both small and large; brown granular amorphous matter; free oil globules; cholesterin crystals; no hematoidin crystals seen.

This fluid contains a large quantity of bile as well as blood. The fatty cells and cholesterin crystals are thoroughly consistent with the fluid of a renal cyst, but I have never known one to contain bile. The very slight quantity of urea might be present in almost any

¹ *The American Journal of the Medical Sciences*, December, 1895.

fluid. The amount of albumin was very large, but the fluid evidently contained a very large proportion of blood, so that no important inference can be drawn from the quantity of albumin.

The operation of nephrectomy was done a few days after the aspiration, under ether anesthesia, by an incision just outside the left linea semilunaris over the center of the tumor. The descending colon was found lying in front of the tumor. The outer part of the mesocolon was incised. The kidney on the right side was found to be normal to the touch, and in position. The tumor was reached through its capsule and enucleated. The pedicle of the renal vessels and ureter were tied with double ligature. There was but one artery.

Before attempting enucleation the parietal peritoneum on the right side of the abdominal incision was sutured to the inner edge of the split capsule of the tumor, thus closing the peritoneal cavity. This prevented the escape of fluid into the peritoneal cavity and kept the contents of the cavity in proper bounds. No drainage was used, and, although a large surface was exposed, all the sides of the wound fell together readily. The woman made an uninterrupted recovery. She went to full term and was delivered without any complication of a living child.

The pathological report by Dr. W. F. Whitney of the Harvard Medical School, was, briefly, "a cystic adenoma of the kidney, with a tendency to a hyaline degeneration of the contents."

To-day, April 27, 1897, a little over three years since the nephrectomy, the patient is well and strong. She has been delivered of a second child, now some ten months old. Urinary examination is as follows:

Urine in twenty-four hours, 900 c.c.; color, normal; reaction, acid; urophein, diminished; indoxyl, increased; urea, 1.89 per cent. (normal); uric acid, increased; albumin, slightest possible trace; sugar, absent; bile pigments, absent; specific gravity, 1021; amount of sediment, considerable; chlorids, normal; sulphates, earthy phosphates, diminished; alkaline phosphates, normal.

Sediment: An occasional hyaline and finely granular cast, rarely one with a blood-globule adherent. An occasional free renal cell and blood-globule. The urine gives evidence of some renal hyperemia.

EDWARD S. WOOD.

This case is of interest for several reasons. It is unusual to find bile-pigment in a cyst of the kidney. The operation did not interfere with the completion of gestation and a normal delivery.

The second pregnancy was normal in every respect.

Closing the peritoneal cavity by suture of the peritoneum before enucleating the cyst is of value, for soiling of the peritoneum and protrusion of bowel are prevented.

There has been no hernia through the abdominal cicatrix, in spite of the fact of two pregnancies since the operation.

It required seven days after the operation for the remaining kidney to secrete what now is the normal amount of urine; namely, about 900 cubic centimeters.

A CONTRIBUTION TO THE STUDY OF BLEEDING STIGMATA.¹

By JAMES NEVINS HYDE, M.D.,

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IN the records of medicine is to be found a relatively small group of cases in which apparently spontaneous hemorrhage is reported as occurring from the cutaneous surface. The papers in which are spread the histories of these cases are variously entitled: "Bleeding, or Bloody, Stigmata," "Bloody Sweat," "Hematidrosis," "Hautblutungen," "Hysterical Stigmata," "Stigmata of Hysteria," and "Ecstasy." The following details are given with a view to illustrating the features exhibited in certain of these cases.

On December 18, 1889, J. P. E., a native of the United States and a resident of Minnesota, presented himself when suffering from a facial eruption. He was a well-developed man, forty-six years of age, married for eleven years, with one healthy child, none dead, and no miscarriages of the wife. He used no tobacco nor alcohol, had no venereal antecedents, and gave no history of previous ill-health. His family record was good. His profession was that of a clergyman, and he was evidently of the number of those who exhibit the mental and moral sensitiveness which often accompanies natural refinement and education. He had studied for a time in Belgium, but since admission to his profession had spent the greater part of his sedentary life in the town where he was then settled.

All his bodily functions were properly performed. He stated that his rectory and church had been recently undergoing repairs, and that he thought his skin had become poisoned by contact with

¹Read before the Twenty-first Meeting of the American Dermatological Association, Washington, May, 1897.

the fresh paint on the walls. His face and scalp only had been involved, and but for one week. He complained of slight pruritus in these regions.

When examined, a number of discrete vesiculo-pustular and pustulo-crustaceous lesions were seen on the affected surface, and there was slight sympathetic irritability of the eyes and eyelids. The notes taken at that date convey no further information respecting the symptoms of this attack. It was regarded as a simple case of dermatitis venenata, and local treatment was ordered which resulted, according to a report made later, in relief of the symptoms. The word "syphilis" had been on the lips of a physician who had casually glanced at the face, but the recognition of the nature of the disorder and its disappearance after the employment of local treatment only, promptly disposed of any such question.

Nothing further was heard of this patient until six years had elapsed. On December 2, 1895, a letter was received from the physician who had first introduced the gentleman, recalling the circumstances of the first consultation and relating the fact of the prompt disappearance of the symptoms shown in the year 1889; but explaining further that from time to time since that date the face and other regions of the body had become the seat of cutaneous hemorrhage. A very slight elevation of the skin appeared first, and this was followed by a prolonged oozing of blood, which occurred day after day. The health of the patient having thus become impaired, he had visited Europe in the year 1894 and while there had applied to a number of clinics for treatment of diseases of the skin, in the hope of securing relief. All these efforts had been fruitless.

On the 6th of the same month the gentleman again presented himself for treatment. As the door was opened to admit him he found it necessary to seize both sides of the casing with his hands in order to prevent himself from falling as he staggered into the consultation-room and swayed heavily to a sitting posture. His face was bloodless, and strongly suggested the characteristic pallor of pernicious anemia. The mucous covering of the lips and conjunctivæ was fully as blanched as the skin of the face. His condition at the moment was one of some gravity, and he was given a stimulant and sent in a conveyance to a private room of the hospital.

Here a careful examination was made of the patient. I requested Drs. Frank S. Johnson and H. B. Favill, both expert clinicians in the field of general medicine, to aid me in the investigation. Later my colleagues informed me that they had not observed a similar case.

Closely questioned on all points, the patient responded that his health, save for the blood-losses and the mental and physical weakness which they had entailed, was satisfactory. He was somewhat subject to constipation and had usually to rise at night in order to empty the bladder. Respecting the frequency and length of duration of the repeated hemorrhages from the skin, he stated that these had been exhausting him for about two years, and had lately increased to such an extent that his professional work had to be abandoned. His body weight had declined from 180 to 159 pounds. His chief subjective sensations, apart from weakness, were nausea and inappetence. In view of his condition, he had prepared himself for what he anticipated as an inevitable end.

Questioned particularly as to the mode of onset of his hemorrhages, he believed that they might have occurred at times from points where the skin had been irritated, but in general such had not been the case, the flow starting spontaneously from the sound and wholly uninjured integument. Almost invariably they had their beginning in the development of a slight elevation of the surface resembling a papule, which burst and was followed by a slow and painless oozing of blood. The loss from a single point in the skin had occasionally persisted for months. At one time six months had elapsed before such a hemorrhage had ceased. There was never any purulent product in any of the papules. On several occasions he had opened them with a needle in order to give exit to the blood which somewhat uncomfortably accumulated at such points.

The sites of these hemorrhages, as far as he could recall them, were capriciously selected. Each, as clearly as it could be recognized by him, was pointed out. His physician had stated that no scars were left. A few very superficial scars were, however, visible, one on the forehead, another below the knee, others on the skin of the belly, and on the arm. These were thin, unattached, delicate, and irregularly outlined, none in its totality larger than an average-sized finger-nail; some with angular, stellate, or rounded projections. The shape of others remotely resembled the trefoil and quatrefoil. Points of former hemorrhages, however, were shown, where no trace of injury of the skin was manifest. The sites of hemorrhages of this class, *viz.*, where no relic of the accident persisted, were decidedly more numerous than the superficial scars. These cicatrices were of a dead-white hue and contrasted vividly with the bloodless tint of the lax, pendulous, and exsanguine skin. At the time of this examination a hemorrhagic point on one side of the lower jaw

had ceased oozing blood but for a few hours. Nothing was visible externally but a linear blood-crust scarcely two millimeters in width and a centimeter in length. When this crust was removed, an ooze of dark-tinted blood followed, which was readily checked by a simple dressing and which did not recur.

The man was stripped naked and every region of the body carefully explored. There was a moderate degree of ptosis of the left upper eyelid, the result of some unsuccessful operation upon the skin of that part. As far as could be determined the viscera were in a normal state. The area of splenic dulness was possibly slightly enlarged, but the spleen was certainly not increased in size. Beyond the evidence furnished by the thin, blanched skin and the few inconsiderable cicatrices, there was certainly a conspicuous absence of signs of disease. In particular, there were no vibices, purpuric points, hemorrhagic striæ, nor tumefactions of the sort to be recognized in certain cases of hemophilia. There were no ecchymoses nor ecchymomata. The urine, carefully examined on two occasions, exhibited no traces of disease. There had never been an admixture of the blood with this secretion, nor had there been at any time blood-losses from the mouth or the bowels. All the bleedings had been limited to the skin, and had occurred in exudations from a single point at one time.

His unaided vision was poor. Dr. Tilley, of the hospital staff, after ophthalmic examination of the eyes, reported that the patient had hyperopia, which would probably be relieved by glasses. The fundus was in good condition.

On examining the blood, it was found by Fleischel's hemometer that the hemoglobin existed in but fifty-five per cent. of the normal amount, indicating thus a shortage of forty-five per cent. As the usual range of variation below the standard of health extends from an extreme of fifteen or twenty per cent. to sixty or seventy, it is apparent that the condition of the blood in the present case bordered on the serious. But thirty per cent. of the normal number of red corpuscles was present, the approximate shortage being set down as nearly sixty-five per cent. The number of leucocytes was not increased, and the possibility of the presence of any one of the leukemic diseases was thus at once set aside.

Numerous small free granules of plasmodia were visible and a large number of characteristic crescents were recognized with ease within the erythrocytes. I made examinations of the fresh blood of this patient, with my associate, Dr. Robinson, at later dates. At no one of these examinations was it difficult to determine the pres-

ence of several of these organisms in any field selected for observation. Few were flagellate; most were endoglobular; and all of the latter exhibited crescentic outlines. They were distinctly of the order of the parasite described by Councilman in 1887, and later in 1895 by Hewetson and Barker, as productive of estivo-autumnal fever. Marchiafava and Celli are in accord with the authors named, in assigning to this organism a longer cycle than that observed by the plasmodia responsible for the ordinary tertian and quartan fevers; its crescentic forms especially existing in afebrile states. The corpuscles in which these organisms existed were not decolorized, the contained body, falciform extremities, and thinned center being recognized with ease. At this time we were unfamiliar with the significance of the deep brassy hue to which experts have called attention as indicative of degenerative changes in the corpuscle; and we cannot, therefore, decide that such changes were in progress.

Sphygmographic tracings of the pulse, under high pressure, under moderate pressure, and under low pressure were taken. They are not strikingly suggestive of much else than a diminished arterial pressure, a fact which was readily established by the unaided touch of the radial pulse.

The patient was placed upon a generous diet, with the administration of iron and quinin internally. His hours of rest and methods of exercise in the open air were carefully controlled. His slight constipation was relieved. As a consequence his restoration to health was gradually, if slowly, secured. Not an insignificant factor in this result was the restoration of hope in the mind of the man himself. No recurrence of the hemorrhages was noted. The patient returned to his home in the latter part of February, and in the course of the following month wrote that he was still rapidly advancing toward a complete restoration of health.

The conclusions apparently warranted by the facts established in this case, after the investigation made by four observers, may be set down as follows:

1. A man fully up to the average in point of development, weight, and precedent health may develop a malarial cachexia without having suffered previously from any of the recognized types of malarial fever, such as the simple or pernicious, intermittent or remittent, or the typhomalarial.

2. Such a subject may suffer from spontaneous hemorrhage from the surface of the skin, occurring from a single point at one time and never from two points simultaneously, the bleedings thus orig-

inated persisting either from one point or in succession from several, for weeks and even months at a time with the result of producing a profound depression of the system and a condition strongly suggestive of pernicious anemia.

3. Blood losses of the sort to be seen in a patient of this class distinctly differ from the hemorrhagic forms of bilious fever where, together with the presence of albumin and renal casts, there are commonly symptoms of hemorrhage from the kidney, and the blood escapes at the same time from multiple points of the skin, as well as from the mouth, the stomach, and the rectum. The well-nigh invariably fatal issue in these cases of so-called hemorrhagic malaria sets them in a category widely different from the rare cases represented by the history here reported.

The objections to an acceptance of these conclusions may be stated as follows:

1. While it is now generally accepted that malaria exists in almost every part of the habitable globe, there had been in the present case a prolonged residence in one of the most healthful districts of this country, the center of the State of Minnesota, at an elevation of more than 1000 feet above the level of the sea, a region, in point of fact, to which persons affected with malarial disease have long resorted, with the happiest effect upon the morbid condition.

2. The patient in this case exhibited absolutely no enlargement of the liver and spleen. It is scarcely necessary to dwell on the importance of this negative fact. There is no writer on the subject of malarial cachexia who does not insist upon the fact of at least splenic enlargement as a pathognomonic symptom.

3. While the presence of plasmodia in the blood of this patient points almost conclusively to the existence of malaria, it is noteworthy that these organisms were recognized again and again at irregularly selected intervals and gave no evidence of observing a cycle or of being associated with changes in the general condition of the patient. It is true that the most careful of modern investigators declare that the length of the cycle of development of the parasites of estivo-autumnal type cannot now be exactly determined, that the crescentic bodies exhibit a special refractoriness to the action of quinin, and that they are often found in afebrile states, but no observer, as yet, has ventured to assign to them a prolonged existence in the blood of the subjects of the disease.

4. And, lastly: All the bodily points indicated by this patient as those from which blood had exuded were those on regions of the body accessible to the hands and on the anterior aspects of the trunk and

limbs. His admission that on occasions some of the lesions upon his skin had been punctured by a needle in his own hands, was not without significance in this connection. It is also to be remembered that the profession of the patient was one which has furnished not a few illustrative examples of hysteria in the male. He was himself, as has been shown, a man of remarkable sensitiveness. He belonged to that wing of his branch of the church whose priests rival and often surpass the extreme sacerdotalism of the religions of the Old World. The word "syphilis" had been uttered in his hearing in connection with his original dermatosis. What self-excoriation, even self-mutilation, may have suggested itself to his mind as a fitting reprisal for such a reproach? One of my colleagues believed that this man exhibited a malarial cachexia, and that his losses were solely due to the resulting depravation of his blood. I am inclined to the belief that the hemorrhages were all self-produced, though it is not, therefore, necessary to assume that the patient was conscious of practising any deceit in the matter. There are strange delusions in the minds of the hysterical which even experts in that field have not yet wholly explained.

Could, however, an anemic state induced by hemorrhages from self-inflicted wounds, whether consciously or unconsciously produced, be merely a step precedent to the implantation and development of plasmodia in the blood? In reply there are no facts that can be cited. Up to the present the literature of the plasmodia has concerned itself exclusively with the etiological value of these organisms in malaria only. Thin of London has, however, recently reported a case in which there was chronic malarial poisoning, with no elevation of temperature and plasmodia present in the blood. It has not yet been shown, nor as yet has the attempt been made to prove, that plasmodia may exist in the blood in the absence of malaria, and as a consequence of an anemic state. It is because these questions are as yet unanswered that I have ventured to digress into the field of general medicine sufficiently far to seek for an interpretation of these curious dermatological phenomena.

A review of the literature more or less directly connected with this subject is not altogether satisfactory in results. Unquestioned confusion is apparent between a number of pathological conditions which have been described under different titles. Of 105 references to the general subject which it has been possible to collect, 43 refer more or less distinctly to what has been termed "bloody sweating" or hematidrosis; 24 to distinctly circumscribed bleedings from the

cutaneous surface; and 38 to the conditions described as bleeding and other "stigmata," "stigmatists," "ecstasy," "trance," etc.

Of the forty-three papers on bloody sweat, one distinctly recognizes the fact that the effused fluid was chromatogenous in character where a micro-organism prevailed. With respect to the others, it does not always appear whether the claim is made that the blood was exuded from the coil-ducts or merely effused in the manner of sweat from the surface of the skin. In one paper, however, it is attempted to show that the sweat-producing glands were the source of the blood. In one of the cases there was nephritic colic; in another, tetanus; in yet another, dementia paralytica. Two of the subjects are distinctly described as neurotic; in one, blood escaped from scars in the skin which were relics of a previous disease. In but one of these cases is the attempt made to connect the occurrence with malaria. In this special instance, the so-called "bloody-sweat" was exuded from the skin of the feet. There are two citations from the writers of antiquity who report *post-mortem* sweating of blood. In addition to the direct bibliographical references, there are eighteen writers who describe bloody sweating without allusion to clinical facts.

Turning to the twenty-four papers on hemorrhage from the skin supposed to be spontaneous in origin, two relate to the occurrence of the accident in neurotic subjects; one to its association with "myelopathic purpura," and one with "cutaneous apoplexy." In one case there was an abundant hemorrhage into and not from the skin. The blood in different cases was poured out from the scalp, eyelids, forehead, nose, temples, nipples, umbilicus, hypogastrium, lumbar region, shoulders, axillæ, arms, palms, and backs of the hands, buttocks, thighs, popliteal spaces, ankles, plantar surfaces, and the toes. In one patient every part of the body save the hairy regions is said to have emitted blood at times; in yet another, the physician anxious to observe with special care asserts that with a glass he saw the blood exuding directly from the orifices of the hair-follicles. The bleeding points in some cases were those where there had originally appeared vesicles; in others there were slight elevations of the surface. The most common coincident cutaneous symptoms were purpuric, petechial, and urticarial. In one of the contributions to the subject made by a member of this Association (Dr. J. C. White) there were both urticarial and bullous lesions.

One of the subjects of this disorder distinctly suffered from a malarial affection, and the case, as reported, conforms strictly to the

type described above as hemorrhagic malaria. There was an effusion described as "bloody sweat" from the head and neck, accompanied by hematuria, with a speedily fatal result.

Glancing over the 38 titles collated under the headings "Stigmata," "Ecstasy," etc., no less than 13 relate to the often-described case of Louise Lateau; 15 are concerned with a description of bleeding and other stigmata, and of the stigmatists; 2 relate to the phenomena of dermographism as associated with the stigmata of hysteria; and 2 are occupied with supposed hemorrhages from the skin resulting from hypnotic suggestion. Three writers discuss the claims to a miraculous origin of cutaneous bleeding.

From this cursory review of the literature of the subject, it appears that a history of repeated and prolonged hemorrhage from the skin of a subject of malaria with eventual restoration of the health, is a rare experience. In the report of the exhaustive analysis of 616 cases of malarial fever made in 1895 by Messrs. Thayer and Hewetson of Baltimore (*Johns Hopkins Hospital Reports*, vol. v, Nos. 1-5, Baltimore, 1895)—one of the most valuable contributions to the disease, as studied by modern methods—no case is reported the clinical facts of which have any relation to those made the subject of this paper.

An attempt to formulate conclusions based upon the mass of evidence furnished by the appended bibliography, would be to little purpose, as many of the observations were imperfectly made and in others the facts were erroneously interpreted. Without much difficulty, however, two distinct classes of these phenomena may be recognized.

As to the first, it is clear that at times spontaneous hemorrhage occurs from one or many points of the skin simultaneously or successively, either as a result of morbid changes in the circulating fluid itself, or as a consequence of disease of other organs of the body, in particular of the nervous centers, of the spleen, of the liver, and of the kidney. One may look with tolerable confidence in the most of these cases, first, for an oozing of blood from many points at a single time rather than from a single point at one time; second, for unquestioned evidence of a morbid state elsewhere than in the skin.

To a second group of cases suspicion attaches by reason of the fact that the effusion of blood from the surface of the integument seems to have shared with spontaneous gangrene in the devices of the impostor. A bleeding skin, whether existing in the deceiver or the self-deceived, appeals to the sympathies of the world in general.

In analyzing the phenomena exhibited in this class of subjects, the possibility is to be set aside, first, of the staining of the physiological excretions of the body by foreign matter or by coloring micro-organisms existing upon its surface; second, of the substitution for human blood of that of some one of the lower animals. When human blood is actually effused from the skin of the subject who himself or herself has been instrumental in producing such a result, not only are all the sites of the hemorrhage, as in the case here related, within easy accessibility of the hands of the patient, but there are mental and nervous changes which require careful recognition. The mental states of these sufferers often defy analysis; among the nervous symptoms may be named disorders of motility and sensibility, including under the latter head, anesthesia, hyperesthesia, and perversion of the special senses of sight, hearing, olfaction, and gustation.

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TWELFTH INTERNATIONAL CONGRESS OF MEDICINE.

MOSCOW, AUGUST 19-26, 1897.

SECTION IN DERMATOLOGY AND VENEREOLOGY.

Pathogeny of Alopecia Areata.—By RADCLIFFE CROCKER of London.

The author described two varieties: (1) neuropathic; (2) parasitic, the latter comprising about ninety per cent. of all cases. The disease is especially frequent where tinea tonsurans flourishes, and the latter may possibly be transformed into the former. There is a variety which bears some relation to seborrhea, but Crocker did not believe Sabouraud had demonstrated that his microbe was the true and only cause of alopecia areata. There lies a great contradiction in clinical facts. Seborrhea and alopecia are very different things, but alopecia is frequent in arthritics. The word should not be applied to the trophoneurotic disease. Contagion is possible, but feeble, and a covering for the head is all that is needed in the way of isolation.

MANASSEÏN of St. Petersburg said that the term *area celsi* should be abandoned. We should use *alopecia areata neuritica* and para-

sitaria, which are distinguished by their etiology and clinical course. From a theoretical viewpoint, a combination of the two cannot be excluded. Neurotic alopecia may develop in apparently healthy subjects; psychical influence plays a rôle in its treatment. Just as its pathological anatomy has been little studied, so there is not a convincing case of parasitic alopecia produced by inoculation of a parasite recognized as specific. These inoculations must be done upon human beings.

BARTHÉLEMY of Paris claimed a parasitic origin for the disease. Contagion is slight, but possible, when the skin is "very acid," *e. g.*, in arthritics. There is no relation between it and seborrhea or trichophytosis. Local isolation, especially in children, is amply sufficient.

CIARROCCHI of Rome, basing his observations on 700 cases, said that in Italy, at least, the disease is progressively increasing. Only thirteen cases showed any evidence in favor of contagion. He had never seen a true epidemic. The patches of alopecia have sites of predilection; mode of disposition, extension, and succession in them follow fixed anatomical laws. There is a genetic relationship between vascular navi, telangiectases, and alopecia; the latter, in a vast majority of instances, is not the result of microbic action *in situ*.

Treatment of Skin and Mucous Membrane Affections by Electric Currents of High Frequency and Tension.—OUDIN and BARTHÉLEMY of Paris claimed that these currents have a powerful trophoneurotic action, and may be employed with success in diseases of various kinds. Certain eczemas, psoriasis, and even lupus are favorably influenced by them. They seem to have a special parasitocidal action, "as proved in the rapid cure of affections exclusively parasitic, such as molluscum contagiosum." The high frequency is obtained in the apparatus of d'Arsonval; the high tension by attaching to it a resonator and a special electrode constituted of a metal wire surrounded by glass, the whole acting as a condenser, which attacks the diseased surface by numerous little sparks.

Toxins in Dermatology.—HALLOPEAU of Paris defines toxins as morbid substances produced by living beings. The essential condition of their production is cellular activity. From the cells they enter the lymph- or blood-circulation, and are eliminated primarily, or secondarily, with the products of secretion; hence, the possible appearance of morbid phenomena upon the skin. They may develop in the subject himself, or in other living beings, and are then of endogenous, exogenous, or of mixed origin. Endogenous toxins may be produced by disturbances of cellular function or reabsorption of normal or altered secretion products. As examples of the first may be mentioned thyroïdin, the products of the suprarenal bodies (melanoderma); of the second may be cited bile, glucose, the urinary and sweat secretions. Exogenous toxins are the poisons, liquid or tissue, of other animal species. Their action may be exerted at the point of entry, producing there, at a distance or generally, a cutaneous outbreak. Certain others, such as mollusks, act

only after ingestion. A number of the latter have been isolated. Among toxins of mixed origin, those of greatest importance are of microbic origin. Absorption of toxic products from a dilated stomach may be a cause of eczema or urticaria; the rose spots of typhoid are a familiar example. The organism is protected against these poisons by the epithelium and the liver. Bouchard and Charin have shown that the toxins possess the same action as the microbes themselves. Injection of tuberculin has caused various exanthems, even lichen scrofulosorum. Some dermatoses due to microbic toxins remain limited to the neighborhood of the point of infection, as in furuncle or condylomata; others give rise, secondarily, to eruptions in which the microbe cannot be found; *e. g.*, tuberculosis and cholera. The erysipelatous outbreaks in leprosy and mycosis fungoides may be ascribed to toxemic invasion. The poisons, very probably, enter into the causation of eczema, psoriasis, purpuras and the non-trophoneurotic pemphigoid eruptions, perhaps, even dermatitis herpetiformis.

Symptomatic Anomalies of Chancre and the Syphilides.—By BARTHÉLEMY of Paris.

There is one among the anomalies of chancre which has not been sufficiently studied, although pointed out by Verchère, *viz.*: its absence. Syphilitic virus does not give rise to a chancre when it passes directly into the blood, or when it is deposited in the subcutaneous tissue without leaving virulent particles in epidermis or corium.

Adenopathy, accompanying chancre, considered as a constant phenomenon, may be absent. The author described such a case, the chancre on the labium majus having been seen by Fournier. Secondary adenopathy appeared toward the end of the roseola.

The ulcerative tertiary syphilides show remarkable anomalies in their evolution. As an example was cited a circinate, ulcerative lesion, the size of a silver dollar, which lasted for eight years in an old syphilitic. In spite of varied and energetic treatment, the syphilide reappeared and persisted after having subsided, as though nothing had been done. Surgical measures, curetting or excision, are indicated, as in tumors, for their removal.

Discussion upon the Treatment of Syphilis.—SCHWIMMER of Budapest believes in specific treatment, administered in sufficient dosage, prolonged, intermittent, and instituted as soon as the diagnosis is made. The treatment should begin early, since it cannot be made preventive.

WATRASZEWSKI of Warsaw is opposed to preventive treatment for several reasons; mercurial anemia, chronic mercurialism, more energetic action of the drug when taken into an organism not previously saturated, etc.

JULLIEN of Paris said that, with few exceptions, modern opinion is in accord on the earliest and most energetic treatment. To combat the disease, the specific must be applied at the earliest moment. His favorite method of treatment is by calomel injection, for which he claimed manifold advantages. As to duration of treatment, a

year at least is necessary, although he did not pretend to say that it should cease then. It is difficult to tell, on account of the recent date of this method, but the patients seem to remain free. The conviction grows on the author that specific treatment of syphilis should be begun before its outbreak.

CASPARY of Königsberg.—Treatment should begin with the appearance of the first indubitable symptoms. Chancre and adenopathy do not come under the heading. Treatment should be energetic, and continued for a few weeks after the disappearance of all lesions. Inunction and injection are always preferable to internal medication. The organism should not be enfeebled; consequently, it is prudent to interrupt medication. Relapse should be managed in the same way, and with every late recurrence treatment should be longer, according to the chronic, interrupted method of Fournier. Even this does not prevent relapse with any certainty.

RESOLIMOS of Athens: In almost all severe, late cases which he had observed treatment had been defective. Syphilis, once manifest, should be treated for four or five years, with intervals of rest. Adjuvant medication for preexistent conditions is often necessary. Except in the tuberculous and those in whom mixed treatment is indicated, mercurials are used to the end. Its administration is varied, by baths, inunction, ingestion, injection, fumigation, his preference being for injection. After the second year each month of treatment is followed by six of rest.

Genital Diabetides in the Male.—**BARTHÉLEMY** said that these affections are rarely seen at their beginning. When they come under the physician's eye they are widely spread, deep, ulcerated, confluent, and infected by various microbes. In one patient, who passed 120 grams of sugar in twenty-four hours and had a little incontinence, there were little rounded, ulcerated lesions produced in the sulcus. No complication, thanks to antisepsis, occurred, but it took three weeks to cure the eruption. Recurrence soon took place, six outbreaks in succession, each appearing as the preceding faded. Diagnosis of herpetiform genital diabetide was made only by exclusion.

Venereal Disease in Prostitutes.—**LIKHATSCHEW** and **ORLOW** of Moscow read a paper on gonorrhea. The localizations of predilection for gonococci are the cervical canal, urethra, and glands of Bartholin. They may remain long in the urethral glands, although not found in the urethra itself. They may be found upon the surface of the labia minora only.

SEREBRIAKOFF of Moscow said that the number of clandestine prostitutes in Moscow increased annually. The majority, after one examination, escape all surveillance. A considerable number of them have lived previously in licensed houses. The number of women affected with syphilis admitted to the municipal hospital is about 50 in 100; those in the secondary period form fully one-third of the total. Clandestine prostitution is the surest agent for the propagation of venereal disease.

BEHREND of Berlin thought that all physicians should, in spite of

the protests of women's associations, demand regulation of prostitution. The sanitary visit should be made at least once a week, and by specialists. Treatment of prostitutes, registered or not, should continue to the time of cure, and be done in hospitals, not clinics. By reason of their vicious habits, they should be separated from other patients. Forced treatment of men and compulsory declaration of syphilis are impracticable. All measures proposed by "abolitionists" show, on their part, dense ignorance of the real state of things.

THE NEW YORK DERMATOLOGICAL SOCIETY.

TWO HUNDRED AND SIXTY-THIRD MEETING, HELD ON TUESDAY
EVENING, SEPTEMBER 28, 1897.

DR. S. LUSTGARTEN, *President, in the Chair.*

A Case of Alopecia Universalis.—Presented by DR. H. G. KLOTZ.

The patient was a boy, aged twelve years. He was born in France, and until six years ago had resided in that country. He had measles when he was four years old, and at the same time whooping-cough, which lasted about six months. Three or four months later his hair began to fall out, especially on the occiput. The bald patches thus formed varied in size from that of a silver quarter to a half-dollar piece. On some of these patches, after a time, the hair returned, while other bald spots appeared elsewhere. The loss of the hair was most marked in the summer, whereas during the cold weather the growth of the hair was more prolific, so that almost the entire head was again covered, with the exception of a few small spots. The newly formed hair was lighter in color and softer than the normal hair. This alternate loss and new growth of the hair continued until last winter; then the patient became progressively balder until the present time, when there are no hairs left excepting a few tufts of light hair over the parietal regions. The eyebrows and eyelashes have also disappeared. The boy is otherwise in good health, and not of a nervous disposition.

DR. S. SHERWELL considered the prognosis fairly favorable. In a number of cases of localized alopecia areata coming under his observation, which had been regarded by others as more or less hopeless, he had obtained very good results with the faradic current, applied by means of a wire brush.

DR. H. G. PIFFARD said the prognosis is favorable in perhaps fifty per cent. of these cases. The treatment suggested by Dr. Sherwell, *i. e.*, the use of the faradic current, had long been recognized as serviceable in certain instances. While he was willing to admit that these two distinct forms of alopecia—neurotic and parasitic—might exist, he had only in a very few instances been able to convince himself that he had arrived at the correct cause of the lesions.

DR. GEORGE T. JACKSON said that the only favorable element in

the prognosis in this case was the youth of the patient. A similar condition in an adult he would regard as much more serious, as in such cases the hair seldom fully returned. As to the use of electricity, he had seen favorable results in the milder cases of alopecia, where the bald patches are small, but in malignant cases like the one before us neither faradism, galvanism, nor static electricity is of much avail.

DR. R. W. TAYLOR said that in some of these cases the prognosis can be based with a fair degree of certainty upon the condition of the skin. After much atrophy of the skin has taken place, with depression of the hair-follicles, then perfect restoration of the hair never occurs; there may, however, be a partial restoration, consisting of a crop of thin, fluffy hair. From the appearance of the scalp in Dr. Klotz's case he thought the prognosis unfavorable.

DR. P. A. MORROW expressed the opinion that it was almost impossible to give a positive prognosis in cases of generalized alopecia. He referred to two cases which occurred in the same family—brother and sister—which were under his observation for a number of years. The sister was supposed to have contracted the disease by wearing her brother's cap, which she frequently did. Both the patients appeared to be enjoying good health, they were both brunettes, and both lost a luxuriant crop of hair, the alopecia in both cases becoming generalized. The sister recovered her hair completely, while the brother is still suffering from complete alopecia, although several years have elapsed.

DR. GEORGE T. ELLIOT said he agreed entirely with Dr. Morrow that a positive prognosis is out of the question in these cases. He mentioned a case of universal alopecia areata which he had seen in Kaposi's clinic in 1880. The patient had had a previous attack, from which he had entirely recovered. The second attack persisted in spite of all treatment.

Dr. Elliot said we know so little about the causation of these cases that the prognosis must necessarily be a waiting one.

DR. S. LUSTGARTEN said that in the so-called malignant cases of alopecia areata the first point is to form an opinion as to whether they are of parasitic origin or not. His own impression was that they are of parasitic origin, differing only in extent from the usual cases of alopecia areata *en plaques*. If they are due to a neurosis, it is certainly remarkable that they have not become a recognized symptom of some of the well-defined nervous conditions.

As regards prognosis, Dr. Lustgarten said he fully agreed with the previous speakers. In one case coming under his observation, a boy of sixteen years, the use of the faradic current for a long time produced no improvement; superficial cauterization with carbolic acid and thyroid extract internally proved equally unsatisfactory. There was only slight temporary improvement. The alopecia in that case was practically universal.

DR. ELLIOT said that in view of the fact that alopecia areata had been produced by cutting the second and third cervical nerves, as well as by various traumatisms, its neurotic origin, in certain in-

stances at least, was unquestionable. On the other hand, it was by no means settled that it could be classed among the parasitic diseases, notwithstanding the investigations of Sabouraud, who had not conclusively proved, in his opinion, its parasitic nature.

DR. C. W. CUTLER said that during the past year he had employed hypodermic injections of the nitrate of strychnia in the treatment of alopecia areata with remarkably good results. The injection is repeated every four or five days, and the dose gradually increased from $\frac{1}{30}$ of a grain to the point of endurance. Externally, as a counter-irritant, he usually employs a mixture composed of carbolic acid, chloral, and tincture of iodine in equal parts. In one case of malignant alopecia areata the above treatment gave very satisfactory results.

DR. LUSTGARTEN, in reply to Dr. Elliot, said that while he did not deny the possibility of an alopecia following nervous disease, still alopecia areata, as a clinical feature, has thus far not been traced to any distinct nervous condition. The experiments of Max Josef, to which Dr. Elliot alluded, are about ten years old, and have not been confirmed sufficiently.

DR. ELLIOT said the experiments of Max Josef and others on animals were confirmed by the numerous cases recorded in literature where alopecia areata followed traumatism of various kinds. In the light of our present knowledge, the neurotic theory of alopecia areata is more likely to be the correct one than the parasitic, which, the speaker thought, had so far only a speculative basis. The claim made by Sabouraud that the lesions were due to a toxin were still inconclusive.

DR. JOHNSTON said that Dr. Elliot was mistaken in his last statement that no inoculation experiments had been made. Sabouraud made many inoculations on rabbits, dogs, and guinea-pigs, and produced by the use of the toxins typical patches of the disease. His experiments, Dr. Johnston said, were certainly as confirmatory as those of Josef.

DR. LUSTGARTEN said he was perfectly well aware that neither the neurotic nor the parasitic theory of alopecia areata had thus far been proven. If the former theory be the correct one, then in a case of universal alopecia areata, like the one which Dr. Klotz presented, we should expect to see other and severe disturbances of a trophic nature; such nervous disturbances, on the contrary, we do not see, and the adherents of the neurotic theory have thus far failed to establish any such clinical connection. Sabouraud's experiments, of course, are still very recent and need confirmation, and his conclusions are not entirely satisfactory.

DR. ELLIOT said it was generally admitted even by Duhring that dermatitis herpetiformis is a neurosis of the skin, and yet it is not necessarily accompanied by other nervous manifestations.

DR. G. H. FOX said that the absence of nervous lesions in vitiligo did not prove that that disease was not of neurotic origin. The same was true of alopecia areata. While the parasitic theory might be the true one, it certainly remained to be proven. In many es-

sential respects, alopecia areata and vitiligo resembled each other, and the speaker said he thought both were the result of faulty innervation of the skin, and were not the result of any local external agency.

DR. PIFFARD said if all cases of alopecia areata were purely neurotic in origin, it would be difficult to account for the epidemics of the disease, occurring in schools and elsewhere, which have been reported by various writers. To show how little advance had been made in our knowledge of this subject during the past twenty years, Dr. Piffard read a quotation from his "Elementary Treatise on Diseases of the Skin," which was published in 1876, and in which the same ground was covered.

DR. P. A. MORROW said there is an immense amount of authentic testimony in favor of the parasitic origin and nature of alopecia areata. In French literature a record may be found of several epidemics occurring among soldiers who were in the habit of wearing each other's caps. In that class of men one would hardly regard hysteria as the causative factor. As a matter of fact, we have the same clinical testimony for believing in the parasitic origin of alopecia areata as in the case of ringworm, excepting that the parasite of the former disease, if one exists, is probably endowed with feebleness of contagious properties, differing in degree rather than in kind.

DR. ELLIOT said the French do not draw sufficiently clear distinction between cases of true alopecia areata and bald ringworm and it was probable that in many of their reported cases the latter affection was mistaken for the former. The one is contagious, while he did not believe the other was.

DR. JACKSON called attention to the fact that the epidemics occurring in the French barracks were among adults, which is a period of life when ringworm is uncommon. The speaker said he did not think we could doubt the correctness of the observations made by our French confrères. It is well recognized that ring-shaped patches may appear on the skin, due to various causes, and he did not see why round patches of baldness might not appear on the scalp, sometimes due to a nerve disturbance; sometimes due to a parasite or other cause.

DR. KLOTZ, in closing the discussion, said that on account of the universal character of the disease in this case, very strong local applications were hardly practicable. He thought favorably of the treatment suggested by Dr. Cutler, although for the present he proposed to try faradisation in accordance with Dr. Sherwell.

The speaker mentioned another case of complete alopecia areata, of which he had spoken at a former meeting of the Society, occurring in a girl about twenty-four years of age; it persisted for several years when, without treatment, a full crop of fine hairs appeared. During the past summer he had seen two cases of alopecia areata, one more pronounced than the other, occurring in twin boys, about sixteen years of age. In that instance the history did not furnish any proof as to the origin.

DR. LUSTGARTEN said there was a case of malignant alopecia

areata on record where the hair reappeared, without treatment, after thirty-three years of baldness.

A Case of Dermographism.—Presented by DR. P. A. MORROW.

The patient was a young man, twenty-four years old, who was subject to dermatographism to a very pronounced degree. Moderate pressure with any blunt instrument would promptly produce distinctly elevated lines corresponding to the tract of irritation. These lines could be readily distinguished across the room. The surface markings of a coin could be readily reproduced on the skin by holding it in contact two or three minutes. He had seen many cases of dermatographism, but none in which the phenomena were so marked a characteristic.

DR. KLOTZ called attention to the absence of any urticarial symptoms and of any neurosis. He referred to a similar case which he had shown last spring.

DR. FORDYCE said it would be interesting, in a case of this character, to examine the blood for the presence of eosinophile cells.

DR. JOHNSTON said it would also be interesting to test the coagulability of the blood, in the direction of the experiments made by Wright, who came to the conclusion that in urticaria the coagulability of the blood is diminished. This led him to the administration of calcium chlorid in such cases.

DR. LUSTGARTEN considers the question of the coagulability of the blood in urticaria and similar reactions of the skin very interesting and inviting to further studies. Conditions like the one presented must be considered a congenital nervous hyperexcitability, either effecting small veins of the skin, if we accept Unna's view; or, the lymphatic capillaries, if we follow Haidenheim; who, on the strength of exact experiments, explains edema, urticaria, and similar conditions to be due to an active secretion of lymphatic capillaries.

DR. MORROW, in closing the discussion, said that dermatographism has always been classed as a vasomotor phenomenon, due to a hyperexcitability of the vasomotor nerves, which is commonly of congenital origin. The fact has been observed, however, that persons with hemiplegia may be subject to dermatographism on the affected side; also, that anesthetic lepers, in whom the nervous system is very much deranged with complete loss of sensation, may present this phenomenon to a remarkable degree, and in some of those cases it is accidentally an acquired peculiarity.

THE NEW YORK ACADEMY OF MEDICINE.

SECTION ON GENITO-URINARY SURGERY,

TUESDAY EVENING, OCTOBER 12, 1897.

RAMON GUITERAS, M.D., *Chairman*.

A Case of Cancer of the Bladder.—Presented by DR. EUGENE FULLER.

In this case soft, rapidly growing cancer involved to a large extent the surface of the bladder around its neck. The growth partially filled the bladder, and the wall was infiltrated. Bleeding was profuse, there was a great amount of pus, and the bladder was foul. The situation of the growth made it impossible to diagnose the case with a cystoscope. The bladder was extremely rigid. The cystoscope is a great assistance in diagnosis, but those having a vivid imagination should avoid its use in these cases. In this case, the man, suffering from great difficulty in emptying the bladder, had seen a number of physicians; one of these saw the middle lobe of the prostate, which acted as a barrier, and he said the case was one of prostatic obstruction; another surgeon said the same; still another did not know what was the matter. Placing the finger in the rectum showed no prostatic enlargement. Under chloroform anesthesia a mass was made out. The fundus of the bladder was drawn up by adhesion toward the umbilicus. A malignant growth was suspected, and found by a suprapubic operation. The man died from extension of the disease.

DR. FERD. C. VALENTINE said that he had nothing to say on the case itself, further than that the diagnosis had been ably made. In regard to the value of the cystoscope, he disagreed slightly with Dr. Fuller. It has been demonstrated that all parts of the bladder can be seen if a proper instrument is used. With Nitze's cystoscope we get an illumination which will enable us to see the middle lobe. With the new instrument, which he will show at the next meeting, he thinks that Dr. Fuller would have had no difficulty in seeing an enlarged middle lobe, if present.

DR. HOWARD LILLIENTHAL asked Dr. Fuller if there was any ulceration. He had seen middle-lobe involvement with the old instrument, and had confirmed his observation by subsequent operation. He said that that part could be plainly seen by rotating the cystoscope on withdrawal.

DR. FULLER, in closing the discussion, again emphasized the fact that no one with a vivid imagination should use the cystoscope. He could have used an instrument in the case cited, but the bleeding would have been so profuse as to obscure vision.

Calculus from Perineum.¹—DR. RAMON GUITERAS read the report of a case with this title.

¹ Will be published.

DISCUSSION.

DR. HOWARD LILIENTHAL opened the discussion. He thought this a very interesting and unique case. He advanced the theory that the urine must have bathed and added by concretion to the stone for it to have attained its present peculiar shape. The stone, after its passage through the urethral wall, had, some time in the past, imbedded itself in the perineum, and he agreed with Dr. Guiteras that this had been done by atrophy, and not by ulceration. The case shows very distinctly the importance of rectal examination in all doubtful cases of rectal or bladder affections.

DR. ALEXANDER said that one point to be noted was that the stone had extended backward and destroyed the rectal wall when it would have been most natural for it to have gone forward. He considered this inexplicable.

DR. FULLER also expressed himself as much interested in the case. Some years ago he read a report in a medical paper where a stone weighing several ounces had worked its way out through the perineum. A cicatrix formed and the man recovered. This stone reached into the bladder. He was of the opinion that in the case just presented the stone would have passed by way of the rectum if the man had not been operated upon. He thought that the stone could work out more easily through the rectum than through the perineum, as the rectum offered the less resistance. He related a prostatic case on which he had operated. After suprapubic opening had been made no evidence of stone could be found. After cutting out an enormous prostate a stone of peculiar shape and weighing about a dram was found; there were many spike-like projections on it. Another stone was found imbedded in the prostate. Dr. Fuller was inclined to think that these stones had been formed in the bladder.

DR. BREWER thought that the flow of urine would naturally push the stone backward, as he endeavored to demonstrate in the diagram.

The Diagnosis and Treatment of Disease of the Inguinal Glands.—By DR. EUGENE FULLER.

Dr. Fuller, in his paper, brought out the great importance of a correct diagnosis, because of its influence on the treatment. The trouble lies in the inguinal glands in but a small majority of the cases. If there is an involvement of the leg or scrotum a chain of glands is affected. In certain conditions one or more glands become involved. Direct traumatism may cause trouble in the gland. This element of traumatism should always be kept in mind. General debility and senility should also be considered. Gonorrheal inflammation always involves the glands to a greater or less extent, and may go on to suppuration. It is rare, however, for gonococci to invade the glands. Chancroidal inflammation always invades the glands, and usually leads to suppuration. Syphilitic inflammation occurs as an early or late manifestation. It is usual for one or two of these glands to become affected. There may be no subjective symptoms. Suppurative buboes may exist from some other cause.

The speaker referred briefly to gumma, its induration and other diagnostic signs. Syphilis, in this connection, should always be considered. Rarely, a tubercular process may bear a resemblance to syphilis, and we should resort to the internal administration of mercury and the iodides to establish a diagnosis.

Tubercular inflammation is not uncommon. It may be an acute, subacute, or chronic affection. When acute there is an active process in the gland structure, and the whole region is apt to become tender. In the diagnosis of this condition look carefully for other signs of the disease. The diagnosis is certain if bacilli are found in the pus. Subacute tubercular adenitis is characterized by marked enlargement. In the chronic form the inguinal glands are dotted with minute abscesses, which coalesce. The tumor may become tender and irritated, and the movements of the individual be impeded. Marked edema may follow. The infiltration slowly works to the surface. Where the condition resembles gumma the presence of the tubercle bacilli serves to make the diagnosis.

Treatment.—When simple inflammation exists, make the patient rest and attempt to heal the primary affection. If the patient is not in poor condition good results follow. Limited motion of the side may be obtained by adjusting a spica bandage. If suppuration threatens the patient should be put to bed and cool lotions or an ice bag should be applied. Painting the surface with tincture of iodine is of no value. Hot flaxseed poultices are to be recommended. In case the abscess points it is best to operate.

If early syphilis is the cause we should resort to mercury and iodides. Gumma of the gland should never be opened, no matter how near the surface it may be; instead use mercurial plaster. If the gumma discharges itself, irrigate the cavity and pack with iodoform gauze. If granulations do not speedily appear bichlorid irrigations can be used.

In tubercular inflammation use general measures which tend to improve the general condition, as malt liquors, tonics, etc. Where one or more sinuses exist, local treatment in the form of an injection of iodoform, 1 dram, to glycerin, 1 ounce. This is forced into the sinuses once a day.

The speaker referred to the different methods of treating suppurating glands, as by aspirating and applying pressure, by aspirating and flushing, and other methods which leave no surface scar. He spoke of using two canulas instead of one, one a little larger than the other. Through the smaller he flushed the cavity with a 1-5000 bichlorid solution; through the other tube he applied the iodoform and glycerin. This method is of use when patient will go to bed. Incision and drainage should be done where it is possible to place the patient in bed, and where the tell-tale scar is not objected to. A free incision should be made, but the knife should not be plunged too deeply. A soft drainage-tube is necessary. Only in tubercular cases is it necessary to enucleate and remove the glands. Enucleation can be best done by shelling the glands out with the fingers. It may be necessary to curette; then irrigate and pack

with iodoform gauze. The wound soon fills with granulations. The patient should not be allowed to remain too long in bed.

In malignant disease all glands should be removed, and that as radically as possible.

DISCUSSION.

DR. GEORGE E. BREWER said that, as to chancroidal bubo, he had found, in the majority of cases, that when they are opened and drained it takes them a long time to suppurate out. He prefers to open freely and enucleate the glands. It takes them too long to break down and discharge. Let the operation be thorough. Tubercular glands in the groin are exceedingly rare, and should be looked out for. The subject is interesting anatomically, because glands follow superficial and deep veins. The enlargement may result from tuberculosis in the region of the lower abdomen, as well as from the penis or scrotum.

DR. GEORGE K. SWINBURNE thought there was but little to discuss concerning the majority of the points made. He disagreed with Dr. Brewer on one point, that was, where operation became necessary, he believed it to be better to open and drain a bubo due to gonorrheal or chancroidal disease, and defer the longer operation of enucleation, which may then be found to be unnecessary in the majority of cases. And on one point he disagreed with Dr. Fuller, believing that, even if the patient refuses to go to bed, we can obtain favorable results in the majority of those cases where the appropriate treatment seems to be the simple, small opening, washing out of cavity, and the injection into the cavity of iodoform and glycerin, or other appropriate medicament, even if these patients do walk about, as Dr. Fuller seemed to lay special stress on the fact that if the patients did walk the operation would fail. If cases are seen early, pressure with a spica bandage seems to favor resolution in some cases. He had frequently noticed that the chancroid or chancre would be on one side of the penis and the bubo on the opposite side, and wished to know whether others had observed the same thing.

DR. BOLESŁAW LAPOWSKI thought there had been no adequate definition given of the term chancroid. What does the term mean? A diagnosis cannot be made out of clinical facts alone. We must use the microscope to differentiate between a simple and virulent disease. A chancroidal bubo needs a special treatment. Chancre, in the French, soft chancre, and here, chancroid, should be opened with a large incision, and any caustic that is at hand may be applied. Rest should follow. Before treating a bubo make an examination of the pus, and find out what kind of a bubo you are treating.

DR. KLOTZ referred briefly to certain buboes which can be distinguished by the fact that they lie firmly imbedded in the underlying tissue. These are characterized by rapid absorption of the fatty tissue. Dr. Klotz exhibited some glands that he had that day removed. They had extended deep down into the muscular tissue, and on one side were closely connected with the saphenous

veins, a condition which he often finds. The glands involved both sides.

DR. GOLDENBERG agreed with Dr. Lapowski. We have a bubo following a soft chancre, which is not truly chancroidal. Out of forty cases he had found only three which showed the bacillus. These latter run a more chronic course, and did not yield to treatment so easily as the others.

DR. BREWER thought, too, that the term chancroid was used rather loosely.

DR. FULLER closed the discussion. In regard to Dr. Swinburne's remarks he wished to say that he had not had the experience that the Doctor had had in treating cases by aspiration and allowing the patients to go about. Dr. Lapowski's remarks were made from the standpoint of a biologist, and not from that of a surgeon. We must do a great deal from clinical observation.

DR. ALEXANDER said, in reference to Dr. Swinburne's question as to crossed lymphatics, that this question had come up before in this very room, and that a study of the lymphatics would show that the condition was to be explained, from the fact that the lymphatics from either side of the penis joined in common trunks before passing to either groin. Therefore, the glands in either groin may be affected with equal ease, no matter which side of the glans penis is affected by the chancroid.

Book Reviews.

International Atlas of Rare Skin Diseases. PART XIII. Leopold Voss, Hamburg and Leipzig.

In Part XIII. of the "International Atlas of Rare Skin Diseases," the high standard of artistic excellence which has distinguished the previous numbers of this series is fully maintained.

Plate xxxviii illustrates a *Peculiar Case of Impetigo Herpetiformis*, by W. Allan Jamieson, M.D. The eruption, which was distributed over the trunk, tips of shoulders, hands, and lower extremities, first appears in the form of minute vesico-pustules, quite superficial, which remain discrete or become blended into larger lesions. Later the eruption shows as hyperemic patches covered with yellow scales and crusts, which, being removed, discloses a raw, exuding surface or a layer of pus.

The fingers are wasted and slightly clubbed. The nails of both hands and feet had disappeared and were replaced by a soft, yellow, closely adherent, crusty mass. The menses had ceased on the appearance of the eruption three years ago and had not reappeared.

Bacteriological examination of the contents of the vesico-pustules revealed the presence of the staphylococcus pyogenes aureus as the active pathogenic organism.

Dr. Jamieson has given the above designation to the eruption from its resemblance to the impetigo herpetiformis of Hebra. He

quotes with approval the opinions of Besnier and Doyon that this dermatosis constitutes one of a group closely united through herpes gestationis with the dermatitis herpetiformis of Dühring.

In plate xxxix, Figs. 1 and 2 illustrate a case of *Tuberculosis Cutanea Frambæsioides Disseminata* by Jessner. Figs. 3, 4, and 5, a case of *Horns Krebs*, by V. Mibelli.

If the diagnosis in Jessner's case is correct, it adds another form to the remarkable polymorphism of cutaneous tuberculosis. The lesions consisted of nearly one hundred small nodular tumors distributed over the face, buttocks, and extremities. They were of a reddish tint, rising abruptly from the sound skin, with a smooth or raspberry-like surface. The epidermal covering was intact, but a probe passed readily into the soft, spongy tissue of which they were composed.

No bacilli were found, but inoculative experiments upon guinea-pigs were held to confirm the tuberculous character of the growths.

The interesting feature of Mibelli's case is the development of a cutaneous horn upon the nose, from a carcinomatous base, which had existed for fifteen years. The combination of carcinoma with cutaneous horns is by no means rare, but the carcinomatous degeneration is usually secondary. In this case it was primary.

Plate xl, Fig. 1, shows *Epithelioma Serpiginoux de la Région Frontale*, by Dr. Georges Thibière; Figs. 2 and 3, *Carcinoma Serpiginosum Multiplex*, by P. G. Unna.

In Thibière's case the entire frontal region, from the root of the nose and supra-orbital ridges upward, is occupied by a vast ulcerative lesion. It was at first suspected to be syphilitic, but the failure of antisypilitic treatment and the later development of certain changes in the borders of the ulceration, led to the revision of the diagnosis. Dr. Thibière points out two features which he regards as valuable in the differential diagnosis of syphilitic ulceration and serpiginous epithelioma. The ulcers scattered on the surface had distinctly defined edges, as if they had been punched out, and in addition, centrifugal extension took place simultaneously with remarkable regularity throughout the periphery of the lesion.

Unna's case is a remarkable example of disseminate carcinoma of the face of a child, which developed from a characteristic dermatosis, beginning with red papules, showing a marked tendency to serpiginous spreading on the surface and central spontaneous healing.

P. A. M.

Traité Pratique des Maladies Vénériennes. BY HENRI BERDAL, M.D. A. Maloine, Paris; 1897.

This volume, which treats of gonorrhea, its complications and treatment, chancroid, bubo, etc., is the first of two parts. The second, which is promised, is to treat of syphilis.

The author recognizes as gonorrhea only that form of urethritis which shows the presence of the gonococcus, and begins the book with a description of that germ, and the various methods of staining, but he does not go beyond that which is entirely practical and of use to

the practitioner. The steps and stages of the course of acute gonorrhea are painted with the minute detail of a Meissonier, which might, perhaps, be pronounced finical by those who prefer a broader brush.

In the treatment of gonorrhea the author is conservatively modern; favors the Janet method, in its proper sphere; but the treatment for chronic prostatitis and chronic seminal vesiculitis is not mentioned; outside of this, the whole ground of modern treatment is pretty well covered, except in the matter of the treatment of urethral stricture, in which there seems to have been but little advance made in the past few years. While many of us, perhaps, do not to-day go so far as we were led by Otis, along these lines, still many valuable lessons were learned from his methods, and it seems strange that he should have been so little heeded in Europe. Oberländer, to be sure, modeled his urethral dilator upon the Otis urethrotome, the leaving out the groove for the knife being almost the only difference.

The author has given us quite a complete and elaborate description of the gonorrhea in the female, devoting several chapters to its consideration. The chapters on latent gonorrhea in women are well worth reading.

There is also a short chapter on gonorrhea in the mouth and rectum, recognizing the advance made in methods of studying this disease.

The chapters on chancroid are written by a passed master. The author believes in the specific influence of the Ducrey-Krefting bacillus as the exciting cause of chancroid.

Under the heading "Affections Paravénériennes," are chapters on herpes of the genitals, vegetations, phimosis, paraphimosis, and phtheiriasis and itch of the genitals.

G. K. S.

Tuberculosis of the Genito-Urinary Organs, Male and Female. PROFESSOR N. SENN, M.D., Ph.D., LL.D. W. B. Saunders, Philadelphia; 1897.

It is only within a few years that the profession has recognized the frequency of the occurrence of tuberculosis of these organs, and the study is still in its infancy, so that this book is a timely one, in that it is destined to bring before a wider circle of readers the importance of this subject, and it serves not only to show what has been accomplished, but it points the way to the wider fields of research.

The book is historical rather than technical, bringing together, within compact and readable form, the results of various investigations along their several lines, which have, until recently, remained scattered through current periodicals.

The author is not afflicted with a personal bias, snubbing the opinions of those with whom he does not agree and giving undue prominence to others; on the contrary, while presenting views which are contradictory, he does it with a harmonizing touch which comes from one who is a seeker after truth.

The book recommends itself to the general practitioner, who first generally sees these cases and should know how to recognize them; and to the specialist as well as the general surgeon.

G. K. S.

The American Year-Book of Medicine and Surgery. Edited by GEORGE M. GOULD, M.D. W. B. Saunders, Philadelphia; 1897.

It is a little late in the day for a review of a '97 year-book, but even with its successor treading on its heels, it deserves particular notice. Drs. Duhring and W. W. Keen have charge of the departments of dermatology and genito-urinary surgery, both of which review in careful and fairly complete manner the work of the previous year. The tome is heavy and unwieldy, but much can be forgiven in that regard in view of the beautiful typographical appearance and the excellence of the illustrations, colored and half-tone.

Selections.

CUTANEOUS DISEASES.

In Charge of Dr. Boleslaw Lapowski.

Miliary Tuberculosis of the Skin and Adjacent Mucous Membrane. Tuberculosis Miliaris. PROFESSOR M. KAPOSI (*Wiener Med. Wochens.*, No. 40, 1897).

In latter years a large group of skin diseases has been placed in the category of skin tuberculosis, either because of the presence of giant-cells or because of finding the tubercle bacillus in the affected tissues, even in very small numbers, sometimes even without its presence, if the results of inoculations have been satisfactory. Greater consideration is given to general pathological conditions, than to accompanying clinical features. To accept as tuberculosis lupus vulgaris, erythematosis, lichen scrofulorum, *post-mortem*-warts, scrofuloderma, felon following different injuries, fungoid growths after chronic joint inflammations, may answer more or less our pathological requirements, but is hardly in accord with our clinical conception of tuberculosis. The foregoing morbid processes not only present clinically totally different pictures in their development, course, prognosis, and therapeutic indications, but they vary greatly histologically and bacteriologically, when compared with the true tuberculosis, as of the lung. For this reason Kaposi and most of the clinicians plead for the recognition only of the circumscribed forms of tuberculosis, established by clinical experience and observation.

Kaposi has repeatedly insisted upon preserving the clinical independence of lupus vulgaris and not yielding to the daily growing inclination of physicians to christen it with the general term "skin tuberculosis," for three important reasons: (1) Histologically, giant-cells and caseous degeneration are no longer regarded as the chief characteristic features of tuberculosis, and even the bacteriological

and experimental facts brought forward since Koch's discoveries are not telling evidences, in the author's opinion; (2) the special clinical characteristics of the development and course of lupus, lasting through the whole life of the patient; (3) there is a skin disease, which is a true tuberculosis, quite like the main type of the disease, namely, miliary tuberculosis of the lungs, and entirely different, clinically and bacteriologically, from other forms of so-called skin tuberculosis, especially from lupus vulgaris and scrofuloderma. This disease is true tuberculosis of the skin, tuberculosis cutis miliaris, and it was recognized long before Koch's discovery of the tubercle bacillus by clinicians as such, especially the forms occurring upon the mucous membrane of the mouth, tongue, and conjunctiva. The involvement of the skin was first noticed by Cornil and Ranvier, who found lesions developed from miliary tubercles upon the face and around the anus in connection with disease in other organs. Jarish published the first clinical description, basing his studies upon Kaposi's cases. Kaposi himself has seen 50 cases in hospital and private practice, but he makes use only of his 22 hospital cases, of whom 18 were men and 4 women, between twenty-eight and sixty years of age. The development of the disease is usually acute, and the prognosis unfavorable, as more than half succumbed; the autopsy showing involvement of the lungs, larynx, intestines, and testicles. In 8 cases only the disease was limited to the skin, selecting the concha of the ears, root, alæ, tip of the nose, septum narium cutaneum, upper and lower lips, corner of the mouth, chin, buttocks, perineal, cubital regions. The clinical character of the disease is mostly expressed in the appearance of the sore. The ulcer is shallow, with an irregular, eroded edge, of light reddish color; the floor is covered with a sero-viscous secretion, slightly infiltrated, and very painful. Very often during the development of the disease tiny, slightly raised tubercles appear near the edge and undergoing destruction, give the characteristic eroded feature to the edge. Sometimes the ulcerated tubercles surround a thin, flat scar, sometimes the central area presents a fungoid papular growth, which does not essentially belong to the process, but presents only a variation in the course of the disease, due to failure of the affected portion to develop a cutaneous covering. The presence of the tubercle bacilli is not constant, not appearing when the destruction and elimination of the primary tubercle is rapid. In making a diagnosis one must be careful not to mistake it for epithelioma, in which the hardness of the base is at variance with the softness in tuberculous ulcers. To differentiate from lupus is not so easy, but the bright red, easily bleeding floor, which is so characteristic for the vascular lupus tissue, the indolent ulcer, the lack of lupus traces in the surrounding skin will be of great help in establishing a correct diagnosis. The prognosis is more favorable than in lupus, as sometimes the tubercles disappear themselves after several years of existence. Sometimes caustics and complete removal where no complications in other organs are present, will bring quite a satisfactory result. In miliary tuberculosis upon the mucous membranes, he described only one very rare

form. Upon the tongue, cheek, and palate there may be observed disseminated foci in the form of very small, red nodules, having sometimes a turbid vesicle on the top, which, undergoing destruction, forms a small, painful, crateriform ulcer. Occasionally they will appear in numbers and quite far from the seat of a large tubercular ulcer, even years after its healing. The prognosis is not very unfavorable if other organs are not deeply affected. He supports this view by histories of two severe cases who have been greatly benefited by local application of iodoform and glycerin (3-5 per cent.) and one hundred per cent. of nitrate of silver.

His conclusions are: (1) Tuberculosis propria seu miliaria cutis is a well characterized disease, different from lupus and other tubercular skin affections; (2) it appears oftener than we are led to believe from the present publications; (3) it generally goes hand in hand with tuberculosis of the respiratory organs, but not always with the last stages or with acute miliary disease of the inner organs; (4) cutaneous may be combined with adjacent mucous-membrane tuberculosis, but often it occurs without it; (5) both forms have a comparatively good prognosis, provided the general condition is satisfactory, and proper treatment is applied.

Acanthosis Nigricans. C. BOECK (*Norsk. Mag. f. Lægevid.*, No. 3, 1897).

Acanthosis Nigricans in its Relations with Abdominal Carcinosis. PAUL COUILLARD (*Gaz. des Hôpitaux*, No. 42, 1897).

Melanosis Accompanied by Moderate Acanthosis. LESLIE ROBERTS (*Brit. Journ. of Derm.*, May, 1897).

Acanthosis Nigricans. M. KUZNITZKY (*Arch. f. Derm. u. Syph.*, t. xxxv, p. 3).

Cutaneous and Vesical Papillomatosis. C. RASCH (*Arch. f. Derm. u. Syph.*, t. xxxvi, p. 55).

Acanthosis Nigricans. V. COLLAN (*Finska Läkarsällskapets Handlingar*, H. 3, p. 419, 1897. From *Annals de Derm. et de Syph.*).

It is extraordinary to be able to present at once so many reports on this rare and interesting affection. Ten cases only had been reported at the time of the writing of Boeck's paper, in March, 1897.

Boeck's patient, a woman of fifty-two, had been operated on three years previously to the appearance of the disease, for cancer of the breast. Pigmentation of the skin began on the neck and spread rapidly to the face and trunk. At the same time, the skin took on an unequal and verrucous appearance. Later, the upper and lower limbs and all the articulations were attacked. On the trunk, the pigmentation and verrucosity were especially marked in the interscapular, umbilical, and genito-anal regions. The tongue and palate developed numbers of long papillomata. The cachexia was progressive and death occurred within two years. The microscope showed increase in the horny and granular layers, with integrity of

the mucous, and in the corium, large numbers of cells, particularly mast-cells. The connective-tissue fibrils were exceedingly fine and thin, forming slight, longitudinal undulations in the papillæ, a disposition which the author regards as essential. There was an extraordinary number of large, ramified chromatophores in the papillæ and in the spaces between the prickle-cells. The author believes administration of extract of the suprarenals prolonged the woman's life.

Couillard's paper is an admirable exposition of the whole subject, with its literature. His conclusions only can be given. The disease is a syndrome dependent upon abdominal carcinosis and characterized (I.) from a clinical view-point by, (1) a papillary hypertrophy and a cutaneous pigmentation having an essentially regional character, (2) a papillary hypertrophy of the mucous membrane, (3) a dystrophy of the hair and nails, (4) absence of desquamation, (5) existence of a cachexia; (II.) from a pathological standpoint, by carcinomatous degeneration of the abdominal organs; (III.) histologically, by lesions of hypertrophy and pigmentation in the Malpighian layer and corium. The term *acanthosis nigricans* should be abandoned in favor of papillary and pigmentary dystrophy (as Darier, its sponsor, frankly says, "*faute de mieux*").

Roberts' patient was a ship-steward. He saved himself in a wreck by clinging to a boat, his legs being constantly immersed in water for ten days. A few months later they swelled from the knee down, the swelling soon disappearing. When first seen, the legs were intensely pigmented with slight desquamation and edema. There was no evidence of papillary outgrowth except in histological section. The horny layer was thickened, prickle-cells enlarged, and palisade-cells and cutis filled with pigment granules, arranged in strata in the corium, partly intra-, partly extracellular. The pigment-cells and granules were often aggregated into masses.

Kuznitzky's case was a woman of forty-one. The disease began on the right breast and appeared successively in all the sites of predilection, all the transition stages being present, from the tiniest elevations to papillomata one centimeter in length. The patient's skin was dark, but the affected areas were peculiarly pigmented. Cancer of the breast developed and was removed, the woman dying of pleurisy. At autopsy, Recklinghausen found atrophy and cancer of the liver. Histological examination showed infiltration of the corium with a notable number of mast-cells. The appearance of condylomata acuminata is surpassed, if possible, by the curious, multiple transformation of the isolated papillæ. The pigment was scattered in irregular fashion. The chromatophores were found principally in the papillary portion, but no relation existed between their abundance and the intensity of papillomatosis. The pigment corpuscles were found free in the lymphatics or enclosed in leucocytes. The epidermal changes did not differ from those described.

Rasch's case is the most interesting and unusual in the collection. There was some doubt in the author's mind as to the proper diagnosis. The patient was a man of seventy-nine who was operated

upon by the suprapubic route for hematuria and frequent urination. A papilloma of the vesical wall was found. Some days after the operation he died and on his body and limbs about twenty fibromatous and papillomatous "nævi" were found. Some showed telangiectases. In the axillary folds and on the arms the verrucous appearance was especially marked. The bladder showed an ulceration in the triangle of Lieutaud. The usual character of warts were found histologically. No mention is made of pigment. The appearance on the skin of papillomata analogous to that of the bladder permits the assertion that the last is congenital origin or developed because of a congenital predisposition. The growths may develop at any age. The latent germ is manifested when the individual becomes old and feeble. Xanthomata, xeroderma pigmentosum, and acanthosis all have internal as well as cutaneous manifestations. ("Nævus" means nothing; the case seems properly classed with acanthosis.)

Collan's case was, like Kuznitzky's, a woman of forty-one. After several months of great pain the disease appeared on the legs and thighs. Extension was progressive, generalization not absolute. The borders of the lids, the labial commissures, and the vaginal lining were attacked, as well as the palate, pharynx, gums, and nostrils. The palms and soles were thick, hard, and dry. The hair fell out and the nails atrophied. Cancer of the stomach was diagnosed from clinical signs. Six illustrations accompanied the text.

Sarcomatosis of the Skin. PROFESSOR TOMASO DE AMICIS (*Monatshefte für prak. Derm.*, vol. xxv, No. 7, 1897).

Sarcomatosis cutis may be of metastatic or primary origin. The primary sarcoma presents itself as a non-pigmentary, a melanotic, or multiple, idiopathic, hemorrhagic growth. The primary melanotic sarcoma may appear upon different parts of the skin, especially upon pigment moles. It grows rapidly, especially when the knife is used. Any interference with it is not advisable. The author gives histories of two cases of non-pigmented and melanotic sarcoma, respectively. The most important form is the third variety—the multiple, idiopathic, pigmented sarcoma. The author has seen about fifty cases of this variety. Often all four extremities are simultaneously affected and sometimes even symmetrically. It may last for a long period—even longer than twenty years—may be occasionally and temporarily improved by the use of arsenic, but usually ends fatally. Microscopically, it represents spindle-cell sarcoma, and the same form is reproduced when a metastatic process is developed in the pleura, stomach, intestines, liver, bone, or even in the nervous system. The glands do not change in the same manner.

Opinions regarding the classification of this disease have changed lately. It is regarded more as a granuloma, because it does not spread, only a few nodules develop, and may undergo involution—properties usually absent in true sarcomata.

Nevertheless, considering the presence of vascularization and spindle-cells, the development of true sarcomata in the internal organs during the latest period of metastasis, and the similarity of structure of the metastatic sarcoma with the primary growth, a relationship between sarcomatosis of the skin and sarcoma must be recognized. Kaposi's suggestion, denominating them sarcoid, should be accepted. There is the same affinity between sarcomatosis of the skin and true sarcoma as between lupus and true tuberculosis of the skin. The etiology of the disease is as yet unknown. All attempts to find micro-organisms, and trials of inoculation, failed. Campana's theory that we have here to do with a disturbance of the central or peripheral nervous system, thus changing the neoplastic conception of the disease to a plain dystrophy, is worth consideration, but hardly acceptable at present. The prognosis is always to be given guardedly, as an involution is not of rare occurrence. Surgical treatment is only advisable in plain, idiopathic, non-pigmented sarcomata, while in the melanotic form the use of the knife leads to very sad results.

In the idiopathic hemorrhagic form the surgical treatment may be used only when we have to deal with one simple cluster, but it is to be avoided if the disease is disseminated. The best results we may obtain from arsenic, but not always. In one variety of the same form, which variety is hardly distinguishable from the other, arsenic will produce very satisfactory effects, while it will utterly fail in the other. In view of this the author is in full accord with the opinion expressed by Fordyce, that in diseases, the real cause of which is unknown, two forms, which clinically appear to us identical, may be due to entirely different factors.

The author reaches the following conclusions: (1) Sarcoma multiplex idiopathicum hemorrhagicum is a separate form, different from mycosis fungoides, and unpigmented and melanotic forms; (2) its place is between granuloma and true sarcoma (sarcoid); (3) the etiology is unknown; (4) a cure is not an impossibility, especially when arsenic is used.

On a Form of Pathological Pigmentation Preceding Malignant Growth of the Skin. JAMES GALLOWAY (*Brit. Med. Jour.*, Oct. 2, 1897, p. 873).

At the Sixty-fifth Annual Meeting of the British Medical Association, Dr. Galloway presented a very interesting and unusual case, a patient with a malignant melanotic growth of the skin, appearing on the sole of the right foot between the first and second metatarsophalangeal joints, following a blister, which always occurred on the same place after the slightest injury. According to the patient's statement, from the first appearance of the blister, it was surrounded by a border of blackish tint. In the beginning the blister would heal in a short time, but later it developed into a persistent sore, which was surrounded on all sides by a margin of brownish-black pigmentation, darker at certain points than at others. There was no sign of swelling; the appearance presented suggested

rather loss of tissue. The glands in the corresponding groin were not enlarged. Nor was there any appearance of undue pigmentation elsewhere. The anterior part of the foot at the tarsometatarsal articulation was amputated with success.

Microscopical examination revealed a malignant growth of epitheliomatous character.

In the case under consideration the lesion commenced on the sole of the foot, away from the nails and even the toes, as is usually seen in such cases, to which Hutchinson gave the name "melanotic whitlow." Although there was no melanotic mole on the spot, the first lesion being a blister, the author is inclined to believe that an undue deposit of pigment took place on the site of the disease and that the area so affected became liable to injury, which, giving a fresh impulse to the extension of the pigment, was the onset of malignant transformation. Microscopically, "the pigment could be seen occupying the lowest columnar cells of the epithelium in a more or less regular manner, presenting an irregular resemblance to the normal distribution of pigment in the darker races. It was difficult to decide whether the pigment was completely cellular or not. It could also be traced into the deeper layers of the cutis."

Note upon the Toxic Effects of the Sweat of a Healthy Man.

S. ARLOING (*Comptes Rend.*, vol. 125, No. 45, 1897, pp. 218-283).

Few experiments have been conducted to show the toxicity or non-toxicity of the sweat of a healthy man. Arloing injected it into the blood of a dog, rabbit, guinea-pig, with the constant result of producing an illness of a varying duration. The duration of the illness, the severity of the symptoms, and the dose necessary to produce death vary with the conditions under which the sweat-glands have eliminated the sweat. For instance, sweat secreted under violent muscular exertion is more toxic than the sweat eliminated in ordinary circumstances. Furthermore, other things being equal, sweat by artificial, sudorific means is very little toxic.

The sweat injected into a dog produces disturbances in various organs, the most severe being in the circulatory system; acting upon the heart, exciting the centers and muscular fiber of the organ. The nervous centers of the respiratory organs are affected also. The temperature usually falls, but it is rapidly recovered if the toxicity of the sweat is not too great, but when the dose is large or the sweat hypertoxic, the temperature falls continuously till death.

Nausea is very pronounced after the injections. The number of blood-corpuscles is diminished, urine contains albumin, the proportion of chlorids, of urea, and of phosphates in the urine is increased immediately after the introduction of the poison. If the quantity of urine secreted during several days after the introduction of the sweat, be taken in consideration, it will be found that the total amount of these substances eliminated is slightly below the normal.

The symptoms in rabbits and guinea-pigs are not so pronounced. To sum up, sweat contains some poisonous substances, affecting all

parts of the organism, changing the composition of the blood, disturbing nutrition, exhibiting a very close analogy to certain microbic toxins.

A Case of Malignant Bullous Dermatitis. DR. ARNOLD SACK
(*Arch. f. Path. Anat. und f. Kl. Med.*, vol. 149, fas. 3, p. 574).

There is a general disposition to exclude from the pemphigus-group acute bullous eruptions, which, accompanied by fever, tend to assume a malignant course and to end lethally. Sometimes such acute bullous eruptions are called acute pemphigus, but it is advisable to place forms with a fatal end in a distinct group till we will know more definitely about the etiology of the disease. The author describes a very interesting case of so-called acute pemphigus under the title given.

A woman, seventy-three years of age, who never before suffered from any pemphigus eruption, was suddenly attacked with severe pain and red patches of a decidedly symmetrical disposition appearing on both flexor surfaces of the arms, both regions of the armpits, back and front of the pubo- and anofemoral aspects. The general condition remained unchanged. Temperature normal.

A short time after the initial painful stage, the symmetrical, red patches changed into blebs, and in some places into papules, both presenting the same symmetrical arrangement as the previous red patches. The largest blebs did not reach the size of a bean. They had tense, strong walls, through which a straw-colored fluid could be seen. The form of the blebs was mostly oval, but longitudinal bullæ were also present. The walls withstood the constant scratching; in some of them, only, the contents became slightly bloody.

On the eighth day the whole aspect of the eruption suddenly changed. Bullæ appeared upon the soft and hard palates, in the vestibule and entrance to the vagina there were clinical symptoms of cystitis, and albumin in the urine. Simultaneously high temperature and delirium appeared, and the disease assumed the character of a malignant infection. The microscopical examination of the urine convinced the author that the mucous membrane of the bladder was also the site of bleb-formation, which was proved by autopsy. The serosanguinolent bleb contents became purulent and the covers ruptured. Even in this condition the eruption kept its strongly symmetrical character, showing denuded, secreting surfaces, without any inflammatory reaction in the neighborhood. On the fourteenth day of the disease the patient died, with symptoms of severe malignant infection. The partial autopsy (the author was not allowed to open the spinal column) revealed bronchopneumonic foci in the lungs, enlargement of the liver, spleen not very enlarged, the kidneys of normal appearance. Larynx and pharynx presented many denuded spots. In the stomach and intestines, only hemorrhagic points, no blebs; in the bladder, eight ulcerations, sharply defined; the rectum also affected. For bacteriological purposes the contents of eight bullæ were used. From two blebs with clear fluid, taken during life, only sterile cultures were obtained; from the re-

maining six, with purulent contents, a rich crop of staphylococcus aureus was reaped, which goes to show that the suppuration was of secondary character, due to the invasion of the staphylococcus aureus. The author, trying to find the way of invasion of the staphylococcus by a very minute microscopical examination of the bleb-covers, saw that the lanugo hairs in the bleb-covers were so tensely stretched by the raised epidermis, that tearing of the hair-bulb follows, thus opening to microbes contained in the hair, among them to the ubiquitous staphylococcus, a clear way to the inside of the bleb, where the staphylococcus, finding a very appropriate soil of serum and blood for its growth, did not fail to take full advantage of the condition. The author is not entirely sure that the contents of the two blebs, taken when the patient was alive, were really sterile, although the cultures did not reveal any microbes. Reasons for his doubt have been furnished to him by the subsequent microscopical examination of the bleb. In the central portion of the bleb, in the deep layers of the rete, he saw an oval zooglea containing diplococci distinctly stained with polychrome methylene-blue. The diplococci had a thin capsule, some of them were grouped in tetrads; and some, especially the young ones, vividly resembled gonococcus. (There is no mention of any symptoms of gonorrhea in the history of the patient. It is to be regretted, but the author did not use a culture-medium appropriate for the gonococcus in examining the contents of the blebs, taken *intra vitam*, as sterility upon agar and gelatin media is characteristic.) The author is of the opinion that there is a connection between this disease and the nervous system. But the question as to the primary cause must be left unanswered.

A Contribution to the Study of Verruca Senilis. GIUSEPPE LUPIS
(*Giornale Ital. d. Mal. Ven. e. del. Pelle*, 1897, Fas. iv, p. 451).

The author endeavors to give an answer to three questions; namely, the histology, contagiousness, and the factor of the contagiousness in verruca senilis. Different writers have published quite a number of cases where the verruca seemed to be transferred either from one portion of a patient's body to another portion by himself, or from one person to another by means of direct or mediate contact. The author relates several cases where the verruca seemed to be transferred from one patient to another. In order to prove the infectiousness of the verruca he inoculated himself with warts, placing them upon two scarified surfaces of his arm, and keeping them there by means of a glass cover for three days. Up to the date of the publication of his article, *i. e.*, twenty-seven months after the inoculation, nothing developed upon the inoculated spot.

He recognizes that to disprove the clinical observations of the seeming infectiousness of warts, inoculations practised upon a large scale are needed. Bacteriological researches revealed only a form of pyogenic staphylococcus which not infrequently we meet upon the normal skin. Cultures, tried upon bread, gelatin, agar-agar, all proved the complete absence of micro-organisms. Histologically,

the hypertrophy of epithelial layers is the primary product of the process, and the papillary hypertrophy is secondary, due to the belated transformation of the Malpighian elements in horny cells.

Warts, and Suggestion. DR. ROUSSEL (*La Loire Médicale*, 1897, t. 9, p. 236).

The author approaches the subject from a new point of view. He is endeavoring to show that suggestion is an important, if not the main factor, in relieving the patient from the warts scattered over a portion of his body.

To support his opinion he states that there are published a good many reliable cases where the warts have been removed by the peculiar "gift" of conjurers. Clinically, it is known that sometimes when one wart is removed the others located far from the one removed disappear simultaneously.

Not only local applications, but also various internal remedies, as monosulphid of sodium, trinitrine, especially magnesia in small doses (0.10 per cent.) will remove the warts, owing not to the action of the remedy, but to the suggestion exercised by the physician upon the patient.

Suggestion is the cause of the disappearance of warts, after covering them with an indifferent powder; also, when, by removing the "mother-verucca" by means of caustics, the remaining fall off—the unconscious suggestion of the physician is the acting factor. When we remember that vasomotor disturbances producing bullæ and even blood-sweat, can be evoked by suggestion, we may be inclined to accept the possibility that a psychical impression may bring forth a change in the anatomical structure of the papillary layer and lead to the disappearance of warts.

GENITO-URINARY DISEASES.

Gonorrhea of the Bladder. WERTHEIM (*Zeitsch. für Geburtshilfe und Gynäkol.*, Bd. XXXV, heft 1).

The occurrence of genuine gonorrheal cystitis has up to the present time almost always been denied by the majority of authors, who have claimed that at most the inflammation is confined to the vesical neck, and that the cystitis following a gonorrhea is always a mixed infection. More recently the presence of a cystitis has been established by means of the cystoscope in cases in which the urine has contained numerous gonococci exclusively. Positive proof of this condition, however, has been established by Wertheim. In the case of a girl, nine years old, suffering from gonorrheal vulvovaginitis, the bladder became affected, the pus from which contained only gonococci. On account of purulent arthritis of the elbow-joint the child was anesthetized, advantage was taken of this to introduce the cystoscope into the bladder, under the guidance of which a small bit of bladder mucous membrane was removed with forceps. Both by the microscope and by cultivation on sterile blood-serum gonococci were found, proving beyond a doubt the existence of

genuine general gonorrheal cystitis, as the bladder under the cystoscope showed a general diffuse inflammation. Further, in the microscopic section some capillaries and small veins were found completely filled with gonococci, a genuine gonorrheal thrombo-phlebitis. (*Centralblatt für die Krankh. d. Harn. und Sexual-Org.*, 1897, p. 521.)

Frequency of Prostatitis and Seminal Vesiculitis in Gonorrhea. COLOMBINI (*Giorn. Ital. delle Mal. Ven. e. della Pelle*, 1896, No. 5).

Out of 400 cases of gonorrhea the author was able, by careful examination, to establish the existence of disease of the prostate, seminal vesicle, or the vasa deferentia in 141, or 35¼ per cent., and that, too, without there being any symptoms in the majority of cases. Of these 400 cases, 160 were acute, in which prostatitis was found 32 times, vesiculitis once, prostatitis and seminal vesiculitis, 15 times. One hundred and eighty cases were subacute; of these 35 had a prostatitis, 4 a vesiculitis, 28 had prostatitis and seminal vesiculitis, and 2 had prostatitis, seminal vesiculitis, and deferentitis. Of 60 chronic cases, 21 had prostatitis, and 3 prostatitis and seminal vesiculitis combined. (*Centralblatt für die Krankh. d. Harn. und Sex.-Org.*, 1897, p. 521.)

The Gonococcus and Public Prophylaxis of Gonorrhea. DR. E. FINGER (*Wien. Klin. Wochenschr.*, 1897, No. 3).

The old teaching that the vagina and not the urethra is the seat of gonorrhea in women has to-day been proven false; likewise, the dogma that a man may get clap from a woman clinically healthy, has been confirmed by modern investigation, *not* however in the sense of its ancient adherents. For many microscopical examinations of the urethral and cervical secretions in prostitutes have shown, on the one hand, that cases clinically healthy may harbor gonococci, and are, therefore, contagious; on the other, cases showing profuse discharge may be found to be free from gonococci and not infectious. This explains why, in the administration of the "Contagious Diseases Prevention Act" (1870-75) in England, the frequency of lues and chancroid was reduced to one-half and two-thirds, while that of gonorrhea remained undiminished. Therefore, mere clinical examination of prostitutes in a measure defeats the end sought, since many non-gonorrheal cases are turned over to the hospitals for treatment because of purulent discharge, and many who are capable of spreading infection are allowed to go free. Finger advises the additional use of the microscope. (*Centralblatt für d. Krankh. d. Harn. und Sexual-Org.*, 1897, p. 518.)

A Case of Virginal Gonorrheal Vaginitis. DR. LEEDOM SHARP (*The Medical News*, Jan. 23, 1897).

The patient, twenty-one years old, complained of severe itching and burning of the genitalia. Vulva and hymen reddened, swollen, and bathed with pus containing gonococci. Hymen intact, allowing only passage of one finger. Vagina hot, mucous membrane swol-

len, covered with pus. The infection was probably from the syringe of a friend who used it first to show the patient how to use it.

Gonorrhea of Rectum. DR. RILLE (*Wiener. Klin. Wochenschr.*, 1897, No. 10).

The author reports the case of a patient, twenty-two years old, having a thin, dirty, gray purulent discharge from the rectum, which was found to contain gonococci in large numbers. The diagnosis was not easy to make clinically, as the anal orifice was bordered with fistulous and fissure-like ulcers, with a pale-red base. The anal folds were swollen, and some of the ulcers extended into the rectum. (*Centralblatt für d. Krankhthn. d. Harn. und Sexual-Org.*, 1897, p. 521.)

Gonorrheal Rectitis. DR. GRIFFON (*La Presse Méd.*, 1897, No. 13).

Secondary anorectal gonorrhea, occurring in women and young girls by propagation from the genitals, cannot be looked upon any longer as an unusual occurrence. On the contrary, the case reported by Griffon, a primary, purely rectal gonorrhea, not anorectal, is unique. The patient, nineteen years old, was a pederast. On July 2d, 1895, he had relations, per anum, with an accomplice who had had a gonorrheal urethritis. July 7th defecation was painful. July 9th at stool on contraction of the anorectal muscle a plug of mucopus was passed. July 14th patient was first seen; the buttocks and anal mucous membrane were clean; the linen bore no spots. The patient by bearing down was able to express the plug of mucopus, which by microscope and culture-tests was found to be richly possessed of gonococci. Daily irrigations of permanganate of potash 1-4000 ordered and kept up till July 25th, and was omitted then for a few days on account of hemorrhoidal swelling at the anal orifice; resumed again when this subsided. Complete cure did not take place till February, 1896. The patient returning to his vicious habits without infecting others, the author held to be proof of complete cure. (*Centralblatt für d. Krankhthn. d. Harn. und Sexual-Org.*, 1897, p. 522.)

A Study of Gonorrheal Arthritis. DR. SCHULLER (*Aerzt. Pract.*, 1896, No. 17. *Monatsber. über d. Krankhthn. d. Harn. und Sexual-Apparates*, 1897, p. 30).

This comprises a study of 52 cases of gonorrheal arthritis extending over a period of 6 years, 34 occurring in men, 18 in women. In 34 cases only one joint was affected; in 18 more than one; generally only two or three, and only exceptionally were none affected. Of the cases in which one joint only was affected, 14 occurred in the knee-joint, 5 in the ankle, in the wrist and in the hip, 2 in the shoulder, 1 metacarpal joint, 1 elbow-joint, and 1 in the abnormal joint between the body and manubrium of the sternum. In the 52 cases 78 joints were affected in the following order: Knee, 29; ankle, 17; wrist, 9; hip, 7; elbow, 6; shoulder, radio-ulnar and metacarpophalangeal, each 3; sternum (between manubrium and

body) one. In addition to the joints, the tendon-sheaths and bursa were frequently affected at the same time. According to the author, we can distinguish between an acute and a chronic joint-affection.

Acute gonorrheal arthritis generally begins suddenly in the course of a gonorrhea, usually with repeated chills, fever up to 40° C. and over, with violent pain in one joint, seldom more. Should more than one joint be affected at the same time, as a rule, the intensity is expended upon one. During the severest pain the joint swells markedly, the skin over superficially lying joints has often an erysipelatous redness, sometimes becoming bluish; the synovia, the periarticular and subcutaneous connective tissue become edematous and unfiltered, and the joint is hot. These symptoms are so characteristic as to make the diagnosis almost certain. In the case of the deeper-lying joints, as the hip and shoulder, the tremendous pain, rendered unbearable by the slightest movement, points to the diagnosis. The exudation into the joint, in majority of cases, is serous, less frequently seropurulent, very seldom pure pus. The chronic form more frequently follows the acute, less frequently begins as such. The symptoms are the same, but less intense, less characteristic. The exudation most frequently is serous. Especially characteristic of the chronic form, whether beginning as such or the result of a previous acute case, is the fact that it may very quickly pass into the acute form or may experience a passing exacerbation.

Gonorrheal arthritis seldom suppurates and seldom results in ankylosis. The author has observed only one case of each. As already mentioned, the tendon-sheaths and bursæ are prone to take part in the affection, especially when the wrist or ankle-joint is affected. Aspiration of these shows a serous fluid or a gelatinous mass. Large collections of fluid in the sheaths of the Peronei, or the tibialis posticus, etc., were observed in nine cases. They have an importance, since if of long standing, they may lead to valgus. The bursa over the os calcis is also frequently affected, and causes that complex symptom, "achillodynia." Further, the bursæ or tendon-sheaths may be affected without the joints being implicated. In one noteworthy case, in addition to coxitis and gonitis on one side, almost all the bursæ of both lower extremities were affected.

As regards therapeutic measures, the author enthusiastically recommends iodid of potassium in solution of 1-40 or 1-50, giving a tablespoonful every two hours. In acute cases this agent acts often with surprising quickness. He recommends besides rubbing in gray salve or carbolic compresses (1-100) once or twice daily, or rest with simple cotton and bandage. Sometimes aspiration (with strict asepsis), followed by irrigation with bichlorid (1-2000), or one-per-cent. Thiersch (boro-salicylic) solution. In very obstinate chronic cases he recommends the aseptic injection of iodoform and glycerin emulsion. In case of suppuration incision, and in case of ankylosis, eventual resection of joint are indicated.

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